ORM R-301A

INSTRUCTIONS FOR EDICAL CERTIFICATE

In giving USE OF DEATH do not enter more than one cause for each f (a), (b) and (c)

his does not mean mode of dying, h as heart failure, ienia, etc. It means disease, or compli- ons which caused th.

onditions, if any, hich gave rise to bove cause (a), tating the under- ying cause last.

Conditions contrib- g to death but not ted to the terminal ase condition given a).

Note:- Chapter 137, cts of 1954, requires ysicians to print or pe the cause or uses of death on ath certificates, and apter 48, Acts of 59, requires Physi- ans to print or type me under signature.

M-6-60-928145

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 1

1 PLACE OF DEATH: Suffolk (County) — Winthrop (City or Town)

No. 80 Upland Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Elmer Stuart Lipsett (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) W.W.1

(a) Residence. No. 80 Upland Road St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 16 years ..... months ..... days. In place of residence 40 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January (Month) 1 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ——, 19—, to ——, 19—

I last saw him alive on ——, 19—, death is said to have occurred on the date stated above, at 11:20 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Natural Causes	
Due To (b) Presumably Coronary Occlusion	sudden
Due To (c) Arteriosclerotic Heart Disease	10 yrs
OTHER SIGNIFICANT CONDITIONS Hypertension	10 yrs

Conditions, if any, which gave rise to the above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

Was autopsy performed? No

What test confirmed diagnosis? post-mortem judgement

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Arthur C. Murray, M. D

Arthur C. Murray (PRINT OR TYPE SIGNATURE)

(Address) Winthrop Board of Health Date 2 Jan 1962

6 Winthrop Cemetery Winthrop, Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 4, 1962 19

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: male

9 COLOR: white

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): married

10a If married, widowed, or divorced HUSBAND of Eva Frances Barrett (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 65 Years 10 Months 26 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Advertising agent (Kind of work done during most of working life)

14 Industry or Business: paper Mfg. Co.

15 Social Security No. 028-03-2352

16 BIRTHPLACE (City) Melrose (State or country) Mass.

PARENTS

17 NAME OF FATHER Andrew Lipsett

18 BIRTHPLACE OF FATHER (City) (State or country) Nova Scotia

19 MAIDEN NAME OF MOTHER Mabel Phillips

20 BIRTHPLACE OF MOTHER (City) (State or country) Maine

21 Informant Mrs. Elmer S. Lipsett (Address) 80 Upland Road, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Simonini (Signature of Agent of Board of Health or other)

Health Officer (Official Designation) 1/3/62 (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE 5-7-1917

DATE OF DISCHARGE 7-1-1919

RANK, RATING ..... Sea 1st Class

ORGANIZATION AND OUTFIT ..... 2nd Detachment Demobilization Camp Devens Green

SERVICE NUMBER 1-407-817

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

ORM R-301A

INSTRUCTIONS FOR DICAL CERTIFICATE

In giving USE OF DEATH

do not enter more than one cause for each (a), (b) and (c)

his does not mean mode of dying, as heart failure, enia, etc. It means disease, or compli- ns which caused h.

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Conditions contrib- g to death but not ed to the terminal se condition given a).

ote:- Chapter 137, of 1954, requires sicians to print or the cause or es of death on h certificates, and pter 48, Acts of , requires Physi- s to print or type e under signature.

OM-6-59-925686

The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Dr King

To be filed for burial permit with Board of Health or its Agent.

Registered No. 2

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. 17 Irwin Street St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

2 FULL NAME Mary K (Butler) Whitehead
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 17 Irwin Street St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years 2 months ....days. In place of residence 37 years ....months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JAN (Month) 1 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from JUNE 28, 1952, to JAN 1, 1962
I last saw h. alive on 12/29/61, death is said to have occurred on the date stated above, at 1235 A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE —	INTERVAL BETWEEN ONSET AND DEATH
(a) Arterio Sclerotic Heart Disease with congestive failure	2 YRS
Due To (b) GENERAL ARTERIO SCLEROSIS	3 YS
Due To (c)	
OTHER SIGNIFICANT CONDITIONS CIRRHIS OF LIVER	7 YRS

Was autopsy performed? No
What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Myron N. King, M. D.
MYRON N. KING M.D.
(PRINT OR TYPE SIGNATURE)
(Address) 1 PLEASANT ST WINTHROP Date 1/2 1962

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Jan. 4 1962

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds
ADDRESS Winthrop Mass.

Received and filed ....19....
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female
9 COLOR White
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Widow

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Alfred E Whitehead
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 76 Years 4 Months 0 Days
If under 24 hours ....Hours....Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own home

15 Social Security No. None

16 BIRTHPLACE (City) County Cork
(State or country) Ireland

PARENTS

17 NAME OF FATHER Edward Butler

18 BIRTHPLACE OF FATHER (City)
(State or country) Ireland

19 MAIDEN NAME OF MOTHER Mary Hennessy
Unable to obtain

20 BIRTHPLACE OF MOTHER (City)
(State or country) Ireland

21 Informant Edna Joseph
(Address) 135 Ocean St. Lynn Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-303

OR TYPE THE CAUSE OR CAUSES OF DEATH ON DEATH CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-3-61-930213

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 3

PLACE OF DEATH

1 SUFFOLK (County)

WINTHROP (City or Town)

No. 400 Revere Street, Winthrop St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME MARGARET I. SHARPE
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence, No. 400 Revere Street, Winthrop St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 25 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January (Month) 2, (Day) 1962 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Arteriosclerotic heart disease.

5 Accident, suicide, or homicide (specify)

Date and hour of injury .....19.....

IF ACCIDENTAL, was injury causally related to the death?

Where did Injury occur? (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)

Manner of Injury (How did injury occur?)

Nature of Injury

While at work? Was autopsy performed? No.

6 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Michael A. Luongo, M. D.
Michael A. Luongo, M.D.
(Print or Type Name)

(Address) Boston Date 1/2 1962

7 Winthrop Place of Burial, or Cremation. Winthrop (City or Town)

DATE OF BURIAL January 5. 1962

8 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed .....19.....

A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 CITIZEN OF U.S.	12 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN
Female	White	YES ☑ NO ☐	☐ ☒ ☐ ☐ ☐

12a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of George Sharpe (Husband's name in full)

13 DATE OF BIRTH May 19, 1891

14 AGE 70 Years 7 Months 14 Days — If under 24 hours .....Hours .....Minutes

15 Usual Occupation: Waitress (Kind of work done during most of working life)

16 Industry or Business: Restaurant

17 Social Security No. 030-22-6753

18 BIRTHPLACE (City) Cambridge (State or country) Mass

PARENTS

19 NAME OF FATHER John McCourt

20 BIRTHPLACE OF FATHER (City) Cambridge (State or country) Mass

21 MAIDEN NAME OF MOTHER Margaret Maxwell

22 BIRTHPLACE OF MOTHER (City) Cambridge (State or country) Mass

23 Informant William Donovan
(Address) 230 Pleasant St Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death with me BEFORE burial or transit permit was issued:

Signature of Agent of

(Official Designation) 1/4/62 (Date)

MEDICAL

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

ORM R-301A

INSTRUCTIONS FOR ICAL CERTIFICATE

In giving SE OF DEATH

do not enter nore than one ause for each (a), (b) and (c)

is does not mean mode of dying, as heart failure, nia, etc. It means lisease, or compli- s which caused

nditions, if any, ich gave rise to ve cause (a), ing the under- g cause last.

Conditions contrib- to death but not d to the terminal e condition given).

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6-60-928145

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 4

PLACE OF DEATH

1 Suffolk (County)

Intrhrn (City or Town)

No. Intrhrn Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Herbert J Swim (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) WW 1

(a) Residence, No. 37 Princeton St. St. Boston Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months 31 days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Jan 2 1962 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec 2, 1961, 19..., to January 2, 1962

I last saw h alive on January 1, 1962, death is said to have occurred on the date stated above, at 6:45 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pulmonary Embolism

Due To (b) Carcinoma of bowel

Due To (c) (Post-operative)

OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given (b).

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signature) Nathaniel P. Danoff, M. D.
(PRINT OR TYPE SIGNATURE)

(Address) 32 Princeton St. E. B. Date Jan. 2 1962

6 Clarks Harbor Nova Scotia
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Jan. 6 1962

7 NAME OF FUNERAL DIRECTOR Frederick J. Magrath

ADDRESS 325 Chelsea St. E. Boston

Received and filed ..... 19...
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male

9 COLOR white

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) married

10a If married, widowed, or divorced HUSBAND of Amaryllis U. Nickerson
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 70 Years.....Months.....Days | If under 24 hours .....Hours.....Minutes

13 Usual Occupation: foreman
(Kind of work done during most of working life)

14 Industry or Business: retired

15 Social Security No. 011-01-3617

16 BIRTHPLACE (City) Clarks Harbor
(State or country) Nova Scotia

PARENTS

17 NAME OF FATHER Nathaniel Swimm

18 BIRTHPLACE OF FATHER (City) Nova Scotia
(State or country)

19 MAIDEN NAME OF MOTHER Olevia Smith

20 BIRTHPLACE OF MOTHER (City)
(State or country) Nova Scotia

21 Informant Amaryllis Swimm
(Address) 37 Princeton St. E. Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

Health Officer 1/3/62
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE 7/30/18

DATE OF DISCHARGE 8/28/19

RANK, RATING Sgt.

ORGANIZATION AND OUTFIT Qtrmaster Corps U.S. Army

SERVICE NUMBER 4306787

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-9-59-926111

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Registered No. 5

Danvers (City or Town making this retu

1 PLACE OF DEATH

Essex (County)

Danvers (City or Town)

No. Danvers State Hospital, Hathorne St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary G. Black (Brooks)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No. 137 Bowdoin Street St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 2 years 4 months 20 days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January (Month) 9, (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from August 20, 1959 to January 9, 1962 I last saw he alive on Jan. 9, 1962 death is said to have occurred on the date stated above, at 7:05p m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: years

Due To (b) Generalized Arteriosclerosis — years

Due To (c) — days

OTHER SIGNIFICANT CONDITIONS Virus infection

Was autopsy performed? no
What test confirmed diagnosis? clinical & Laboratory

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) Andrew Nichols III Andrew Nichols III, M. D.
(Address) Hathorne, Mass. Date 1/9/ 1962

6 Winthrop Cemetery, Winthrop
Place of Burial or Cremation (City or Town)
DATE OF BURIAL January 11, 1962

7 NAME OF FUNERAL DIRECTOR Howard Reynolds
ADDRESS Winthrop, Mass.

Received and filed Feb 8 1962
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female

9 COLOR white

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) widowed

10a If married, widowed, or divorced ~~xxxxxxxx~~ 1. Charles McHatton
(Give maiden name of wife in full)
(or) WIFE of 2. Fred Black
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 84 Years 10 Months 29 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Domestic
(Kind of work done during most of working life)

14 Industry or Business: .....

15 Social Security No. Unknown

16 BIRTHPLACE (City) Meriden
(State or country) Connecticut

PARENTS

17 NAME OF FATHER 1st. name unknown, Brooks

18 BIRTHPLACE OF FATHER (City) Unknown
(State or country) Unknown

19 MAIDEN NAME OF MOTHER Mary, maiden name unknown

20 BIRTHPLACE OF MOTHER (City) Unknown
(State or country) Unknown

21 Informant Georgie T. Brimigion
(Address) Hathorne, Mass.

A TRUE COPY
ATTEST: [signature]
(Registrar of City or Town where death occurred)

DATE FILED January 16, 1962

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

FORM R-302

MARGIN RESERVED FOR BINDING — WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12. G. L.)

50M-9-59-926111

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Cambridge
(City or Town making this return)

Registered No. 33 6

1 PLACE OF DEATH
Middlesex (County)
Cambridge (City or Town)
No. Guardian Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Margaret Emma Pontiff
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR.....)

(a) Residence. No. 66 Winthrop Shore Drive St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days. 6

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 10, 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan. 4, 62 to Jan. 9, 62 I last saw h.....alive on Jan. 9, 62 death is said to have occurred on the date stated above, at 6:50A.M.

INTERVAL BETWEEN ONSET AND DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Cerebral Thrombosis with left hemiparesis

Due To (b) Hypertension

Due To (c) Gastric Carcinoma with Peritoneal metastases

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no
What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) Henry S. Robinson M. D.
(Address) 363 Washington St. Somerville Date Jan. 10, 62

6 Place of Burial or Cremation St. Patrick's Cem. Fall River (City or Town)
DATE OF BURIAL January 12, 62

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Haley
ADDRESS Winthrop, Mass.

Received and filed Feb. 1 1962
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female
9 COLOR White
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Widowed

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Eugene J. Pontiff
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 80 Years.....Months.....Days. If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Retired Nurse
(Kind of work done during most of working life)

14 Industry or Business: Nursing

15 Social Security No.

16 BIRTHPLACE (City) Fall River Mass.
(State or country)

PARENTS

17 NAME OF FATHER Daniel J. Sullivan

18 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

19 MAIDEN NAME OF MOTHER Margaret Murphy

20 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)

21 Informant Eugene J. Pontiff
(Address) 66 Winthrop Shore Drive Fall River

A TRUE COPY
ATTEST: Paul E. Healey
(Registrar of City or Town where death occurred)

DATE FILED Jan. 11, 1962

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

RM R-301A

568

NSTRUCTIONS FOR CAL CERTIFICATE

In giving SE OF DEATH

o not enter ore than one use for each a), (b) and (c)

s does not mean mode of dying, as heart failure, ia, etc. It means isease, or compli- s which caused

ditions, if any, ch gave rise to ve cause (a), ing the under- g cause last.

onditions contrib- to death but not l to the terminal e condition given

ote:- Chapter 137, s of 1954, requires sicians to print or the cause or es of death on h certificates, and pter 48, Acts of , requires Physi- s to print or type e under signature.

5-60-928145

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 7

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. 113 Pleasant St. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Frederick B (First Name) O'Regan (Middle Name) (Last Name) (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 113 Pleasant Street St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 19 years ... months ... days. In place of residence 19 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January (Month) 11 (Day) 1962 (Year)

4 I HEREBY CERTIFY. That I attended deceased from April 27, 1954, to January 11, 1962

I last saw him alive on Dec. 11, 1961, death is said to have occurred on the date stated above, at 6.30 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute Myocardial Infarct, 8m 1hr

Due To (b) Coronary Sclerosis 1954

Due To (c)

OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? No

What test confirmed diagnosis? Electrocardiogram

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) George H. Lynch, M. D.

George W. Lynch (PRINT OR TYPE SIGNATURE)

(Address) 520 Comm. Ave. Boston Date Jan. 11 1962

6 Holyhood Cemetery Brookline Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 15 1962

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed JAN 15 1962 19 (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male

9 COLOR White

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Married

10a If married, widowed, or divorced HUSBAND of F. Lucille Grimes (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 68 Years ... Months ... Days If under 24 hours ... Hours ... Minutes

13 Usual Occupation: Medical Doctor (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) Boston (State or country) Mass

PARENTS

17 NAME OF FATHER William O'Regan

18 BIRTHPLACE OF FATHER (City) Boston (State or country) Mass

19 MAIDEN NAME OF MOTHER Julia Callahan

20 BIRTHPLACE OF MOTHER (City) Boston (State or country) Mass

21 Informant F. Lucille O'Regan (Address) 113 Pleasant St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit) 1/12/62

V.L.V.

RECEIVED

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-303

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-3-61-930213

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 8

1 PLACE OF DEATH: SUFFOLK (County) WINTHROP (City or Town)

No. 5 Irwin St., Winthrop St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME ALICE C. EAGAN (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) No.

(a) Residence, No. 5 Irwin Street (Usual place of abode) St. Winthrop, Massachusetts (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January (Month) 12, (Day) 1962 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

5 Accident, suicide, or homicide (specify) .....

Date and hour of injury .....19.....

IF ACCIDENTAL, was injury causally related to the death? .....

Where did Injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)

Manner of Injury ..... (How did injury occur?)

Nature of Injury .....

While at work? ..... Was autopsy performed? NO

6 Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) Leonard Atkins, M. D.

Leonard Atkins, M.D. (Print or Type Name)

(Address) 25 Shattuck St. Date 1/12/ 1962

7 Needham Cemetery, Needham (Place of Burial, or Cremation) (City or Town)

DATE OF BURIAL January 15 1962

8 NAME OF FUNERAL DIRECTOR Joseph A Faffon

ADDRESS 1305 Highland ave Needham, Mass

Received and filed JAN 15 1962 19.....

A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 CITIZEN OF U.S.	12
FEMALE	WHITE	YES ☒ NO ☐	SINGLE ☐ MARRIED ☐ WIDOWED ☒ DIVORCED ☐ UNKNOWN ☐

12a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of James E. Eagan
(Husband's name in full)

13 DATE OF BIRTH .....

14 AGE 75 Years.....Months.....Days. If under 24 hours .....Hours.....Minutes

15 Usual Occupation: Registered Nurse (Kind of work done during most of working life)

16 Industry or Business: Winthrop Hospital

17 Social Security No. .....

18 BIRTHPLACE (City) (State or country) Brockton Mass

PARENTS

19 NAME OF FATHER John W. McGowan

20 BIRTHPLACE OF FATHER (City) (State or country) (Unknown)

21 MAIDEN NAME OF MOTHER (Unknown)

22 BIRTHPLACE OF MOTHER (City) (State or country) (Unknown)

23 Informant Mr John Eagan Son
(Address) Richard Rd. Needham

I HEREBY CERTIFY that a satisfactory standard certificate of death filed with me BEFORE the burial or transit [illegible]ed:
Ralph E. Stevens
Agent of Board of Health or other
Ralph E. Stevens Jan. 15 1962
(Official Designation) (Date of Issue of Permit)

MEDICAL

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

RM R-301A

NSTRUCTIONS FOR CAL CERTIFICATE

In giving SE OF DEATH

o not enter ore than one use for each a), (b) and (c)

does not mean node of dying, as heart failure, ia, etc. It means sease, or compli- which caused

ditions, if any, h gave rise to e cause (a), ing the under- g cause last.

onditions contrib- to death but not to the terminal condition given

e:- Chapter 137, of 1954, requires cians to print or the cause or s of death on certificates, and er 48, Acts of requires Physi- to print or type under signature.

M-6-59-925686

The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 9

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Mounts Convalescent Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

2 FULL NAME Annie Lucy Hurley
(If deceased is a married, widowed or divorced woman, give also maiden name.)
Annie Lucy Hurley

(a) Residence. No. 83 Loring Rd St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 4 years 9 months 22 days. In place of residence 30 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January (Month) 14 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from April 23, 1957, to January 14, 1962,
I last saw he alive on January 9, 1962, death is said to have occurred on the date stated above, at 12:10 P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Arteriosclerotic Heart Disease	5 yrs
Due To (b) Arteriosclerosis	10 yrs
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? No
What test confirmed diagnosis? Clinical Finding

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) John F Collins MD, M. D.
John F. Collins MD
(PRINT OR TYPE SIGNATURE)
(Address) 22 Bennington St Revere Date 14 Jan 1962

6 Holy Cross Malden Mass
Place of Burial or Cremation (City or Town)
DATE OF BURIAL January 16 1962

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
ADDRESS Winthrop Mass

Received and filed JAN 15 1962 19
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE (write the word) MARRIED WIDOWED or DIVORCED: Single

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 91 Years Months Days — If under 24 hours Hours Minutes

13 Usual Occupation: At Home
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) Boston
(State or country) Mass

PARENTS
17 NAME OF FATHER Jeremiah Hurley
18 BIRTHPLACE OF FATHER (City)
(State or country) Ireland
19 MAIDEN NAME OF MOTHER Annie Barret
20 BIRTHPLACE OF MOTHER (City)
(State or country) Ireland

21 Informant Charles Blais
(Address) 83 Loring Road Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Walter C. Freeman
(Signature of Agent of Board of Health or other)
Health Officer 1/15/62
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

RM R-301A

INSTRUCTIONS FOR ICAL CERTIFICATE

In giving SE OF DEATH

o not enter ore than one use for each 1), (b) and (c)

does not mean mode of dying, as heart failure, a, etc. It means sease, or compli- which caused

ditions, if any, h gave rise to e cause (a), ing the under- g cause last.

nditions contrib- to death but not to the terminal condition given

te:- Chapter 137, of 1954, requires icians to print or the cause or s of death on l certificates, and ter 48, Acts of 5 requires Physi- . to print or type under signature.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 10

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

Marblehead 2-9-62

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) —

2 FULL NAME Mary R. Kidder
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. 44 Maple St., Marblehead Mass. St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months 68 days. In place of residence 30 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 17 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov 16, 1961 to JAN. 17, 1962
I last saw her alive on JAN. 17, 1962, death is said to have occurred on the date stated above, at 7:05 P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Carcinomatosis	weeks
Due To (b) Carcinoma of liver	1 years
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Ascites	3 month

Was autopsy performed?
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Joseph Grieve, M. D.
(PRINT OR TYPE SIGNATURE) JOSEPH GRIEVE
(Address) 164 Washington St. Date 1/17 1962

6 Place of Burial or Cremation WATERSIDE CEM, MARBLEHEAD (City or Town)
DATE OF BURIAL JAN. 20, 1962 19

7 NAME OF FUNERAL DIRECTOR GLOVER G. EUSTIS
ADDRESS 142 ELM ST, MARBLEHEAD

Received and filed JAN 1 1962 19
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: FEMALE
9 COLOR: WHITE
10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): WIDOWED

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of ARTHUR C. KIDDER
(Husband's name in full)

11 IF STILLBORN, enter that fact here. —

12 AGE 59 Years 4 Months 12 Days
If under 24 hours ....Hours....Minutes

13 Usual Occupation: SCHOOL TEACHER
(Kind of work done during most of working life)

14 Industry or Business: TOWN OF MARBLEHEAD

15 Social Security No.

16 BIRTHPLACE (City) MARBLEHEAD
(State or country) MASS

PARENTS

17 NAME OF FATHER CHARLES F. DOE

18 BIRTHPLACE OF FATHER (City) MARBLEHEAD
(State or country) MASS

19 MAIDEN NAME OF MOTHER ANNIE P. HARRIS

20 BIRTHPLACE OF MOTHER (City) MARBLEHEAD
(State or country) MASS

21 Informant MRS JOSEPH SMETHURST
(Address) ANDOVER, MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
(Signature of Agent of Board of Health or other)
(Official Designation) (Date of Issue of Permit) 1/19/62

1-60-928145

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-302

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-9-59-926111

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Cambridge (City or Town making this return)

Registered No. 91 11

1 PLACE OF DEATH: Middlesex (County); Cambridge (City or Town); No. Mt. Auburn Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: Max Yorks (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, If so specify WAR, no)

(a) Residence. No. 290 River St. St. Winthrop (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..years 1 months 17 days. In place of residence 20 years ..months ..days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 20, 1962 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 12-3 1961 to 1-20 1962

I last saw h. alive on 1-20 1962, death is said to have occurred on the date stated above, at 6:18P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Glioma of Brain — INTERVAL BETWEEN ONSET AND DEATH: 9wks.

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? yes

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Samuel Lowis M. D.

(Address) 475 Comm. Ave. Boston Date 1-21 1962

6 Ohel Jacob Cem. Woburn Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 21, 1962

7 NAME OF FUNERAL DIRECTOR Benjamin Birnbach

ADDRESS 10 Washington St. Dorchester

Received and filed Feb. 7, 1962

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Married

10a If married, widowed, or divorced. HUSBAND of Ida Bix (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 54 Years 8 Months 1 Days — If under 24 hours ..Hours ..Minutes

13 Usual Occupation: Real Estate (Kind of work done during most of working life)

14 Industry or Business: Self Employed

15 Social Security No.

16 BIRTHPLACE (City) E. Boston (State or country) Mass.

PARENTS

17 NAME OF FATHER Abraham Yorks

18 BIRTHPLACE OF FATHER (City) (State or country) Lithuania

19 MAIDEN NAME OF MOTHER Rose Kapulsky

20 BIRTHPLACE OF MOTHER (City) (State or country) Lithuania

21 Informant George Yorks (Address) 60 Sawmill Rd. Bristol, Conn.

A TRUE COPY

ATTEST: [illegible] (Registrar of City or Town where death occurred)

DATE FILED Jan. 23 1962

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

FORM R-301A

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

Note:- Chapter 137, Acts of 1954, requires physicians to print or type the cause or causes of death on death certificates, and Chapter 48, Acts of 1955 requires Physicians to print or type name under signature.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 12

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town); No. 6 Hutchinson St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Eric Brian Stone (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 6 Hutchinson St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JAN (Month) 24 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from JAN. 22, 1962, to JAN 24, 1962. I last saw him alive on Jan 24, 1962, death is said to have occurred on the date stated above, at 8 10 A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Acute gastroenteritis	2 days
Due To (b) Acute pharyngitis, otitis media PHARYNGITIS OTITIS MEDIA	2 days
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Moderate dehydration, sepsis	1 day

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify

(Signed) William O'Hare, M. D.
William Oldrieve, M.D.
(PRINT OR TYPE SIGNATURE)
(Address) ..... Date 19

6 Shawmem Park, Shawsen
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Jan 25 1962

7 NAME OF FUNERAL DIRECTOR Joy Funeral Service
ADDRESS 6 Bartlett

Received and filed JAN 25 1962 19.....
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE (write the word) ~~MARRIED~~ ~~WIDOWED~~ or ~~DIVORCED~~: Single

10a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 0 Years 8 Months 13 Days | If under 24 hours .....Hours.....Minutes

13 Usual Occupation: At home
(Kind of work done during most of working life)

14 Industry or Business: None

15 Social Security No. None

16 BIRTHPLACE (City) (State or country) Boston Mass

PARENTS:

17 NAME OF FATHER Hubert L. Stone

18 BIRTHPLACE OF FATHER (City) Boston (State or country) Mass

19 MAIDEN NAME OF MOTHER Anita Casolan

20 BIRTHPLACE OF MOTHER (City) Everett (State or country) Mass

21 Informant Hubert L. Stone
(Address) 6 Hutchinson St Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

[illegible]
(Signature of Agent of Board of Health or other)

[illegible]
(Official Designation) (Date of Issue of Permit)

OM-11-59-926662

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

ORM R-301A

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each (a), (b) and (c)

This does not mean the mode of dying, as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a).

Note:- Chapter 137, Acts of 1954, requires physicians to print or type the cause or causes of death on death certificates, and Chapter 48, Acts of 1955 requires Physicians to print or type under signature.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 12

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town); No. 6 Hutchinson St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Eric Brian Stone (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 6 Hutchinson St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JAN (Month) 24 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from JAN. 22, 1962, to JAN 24, 1962

I last saw him alive on Jan 24, 1962, death is said to have occurred on the date stated above, at 8 10 A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Acute gastroenteritis	2 days
Due To (b) Acute pharyngitis, otitis media PHARYNGITIS OTITIS	2 days
Due To (c) MEDIA	
OTHER SIGNIFICANT CONDITIONS Moderate dehydration, sepsis	1 day

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify

(Signed) William Glazier, M. D.
William Glazier M.D.
(PRINT OR TYPE SIGNATURE)
(Address) ..... Date ..... 19..

6 Sharon Mem Park, Sharon
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Jan 25 1962

7 NAME OF FUNERAL DIRECTOR Torf Funeral Director
ADDRESS Brockton

Received and filed JAN 25 1962 19..
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE (write the word) ~~MARRIED~~ ~~WIDOWED~~ or ~~DIVORCED~~: Single

10a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 0 Years 8 Months 13 Days — If under 24 hours .....Hours.....Minutes

13 Usual Occupation: At home
(Kind of work done during most of working life)

14 Industry or Business: None

15 Social Security No. None

16 BIRTHPLACE (City) (State or country) Boston Mass

PARENTS

17 NAME OF FATHER Hubert L. Stone

18 BIRTHPLACE OF FATHER (City) (State or country) Boston Mass

19 MAIDEN NAME OF MOTHER Anita Casdan

20 BIRTHPLACE OF MOTHER (City) (State or country) Everett Mass

21 Informant Hubert L. Stone
(Address) 6 Hutchinson St Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

[illegible]
(Signature of Agent of Board of Health or other)

[illegible] 1/24/62
(Official Designation) (Date of Issue of Permit)

OM-11-59-926662

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

ORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-8-56-918227

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Registered No. 13

X

PLACE OF DEATH

1 Essex (County) — Lynn (City or Town making this return)

Lynn (City or Town)

No. Lynnview Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

VOTING PL. Lithan

2 FULL NAME Anne Piper (Hartin)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 97 Washington Avenue St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..years 2 months ..days. In place of residence 40 years ..months ..days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 29, 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan. 8, 19 62, to Jan. 29/62, 19..
I last saw he alive on Jan. 27/62, 19.., death is said to have occurred on the date stated above, at 11:20 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Adenocarcinoma of pancreas

Due To
(b)

Due To
(c)

OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

Was autopsy performed? no
What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) Clarence London, M. D.
(Address) Lynnview Hosp. Date 1/29/62, 19..

6 Forest Hills Boston
Place of Burial or Cremation (City or Town)
DATE OF BURIAL February 1/62 19..

7 NAME OF FUNERAL DIRECTOR Maurice W. Kirby
ADDRESS Winthrop, Mass.

Received and filed Feb 5 1962 19..
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female
9 COLOR: white
10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): widow

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Harold W. Piper
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 68 Years 1 Months 0 Days — If under 24 hours ..Hours ..Minutes

13 Usual Occupation: Clerk
(Kind of work done during most of working life)

14 Industry or Business: Town Hall, Winthrop

15 Social Security No.

16 BIRTHPLACE (City) Boston
(State or country) Mass.

PARENTS

17 NAME OF FATHER John J. Hartin

18 BIRTHPLACE OF FATHER (City)
(State or country) Ireland

19 MAIDEN NAME OF MOTHER Elizabeth McElroy

20 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Mass.

21 Informant Miss Virginia Keeler
(Address) Havolon Rd., Milton, Mass.

A TRUE COPY
ATTEST: Albert L. Stymm
(Registrar of City or Town where death occurred)

DATE FILED Jan. 31/62 19..

V.R.V

RM R-301A

STRUCTIONS FOR AL CERTIFICATE

In giving E OF DEATH

o not enter re than one ise for each), (b) and (c)

h does not meon ode of dying, s heart foilure, ea, etc. It means ease, or compli- which caused

ditions, if any, h gave rise to e cause (a), g the under- e cause lost.

nditions contrib- o death but not to the terminol condition given

Note:- Chapter 137, of 1954, requires ians to print or the cause or s of death on certificates, and er 48, Acts of requires Physi- to print or type under signature.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 14

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town); No. Bay View Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Edward Everett Sargent (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO.

(a) Residence. No. 195 Winthrop Street St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 1 years 9 months days. In place of residence 40 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February (Month) 4 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from February 16, 1961, to February 4, 1962

I last saw him alive on February 3, 1962, death is said to have occurred on the date stated above, at 7:55 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Arteriosclerotic & hypertensive Heart Disease	2 yrs.
Due To (b) Generalized arteriosclerosis	3 yrs.
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Prostatic hypertrophy	3 yrs.

Was autopsy performed? NO
What test confirmed diagnosis? Clinical & Laboratory

5 Was disease or injury in any way related to occupation of deceased? No.
If so, specify

(Signed) Maurice Traunstein, Jr., M. D
M. Traunstein, Jr., M.D.
(PRINT OR TYPE SIGNATURE)
(Address) 73 Bartlett Rd. Winthrop 52, Massachusetts Date FEB. 5, 1962

6 Woodlawn Cemetery Everett, Mass.
Place of Burial or Cremation (City or Town)
Cremation
DATE OF BURIAL February 6, 1962

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh
ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed FEB 6 1962
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: male
9 COLOR: white
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word): married

10a If married, widowed, or divorced
HUSBAND of Gertrude Rose Andrews
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 92 Years 3 Months 15 Days | If under 24 hours Hours Minutes

13 Usual Occupation: retired printer
(Kind of work done during most of working life)

14 Industry or Business: Commercial Printing Co.

15 Social Security No. 023-16-9856

16 BIRTHPLACE (City) Haverhill
(State or country) Massachusetts

PARENTS

17 NAME OF FATHER David Pillsbury Sargent

18 BIRTHPLACE OF FATHER (City) Haverhill
(State or country) Massachusetts

19 MAIDEN NAME OF MOTHER E. Bartlett May

20 BIRTHPLACE OF MOTHER (City) Haverhill, Mass.
(State or country)

21 Informant Mrs. Edward E. Sargent
(Address) 364 Winthrop St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit) 2/6/62

60-928145

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

RM R-301A

STRUCTIONS FOR DAL CERTIFICATE

In giving UE OF DEATH

not enter nre than one c se for each), (b) and (c)

h does not mean ode of dying, s heart failure, en, etc. It means ease, or compli- which caused h

ntions, if any, hi: gave rise to o cause (a), g the under- in cause last.

Conditions contrib- g o death but not e to the terminal condition given a)

Note:- Chapter 137, of 1954, requires cians to print or the cause or s of death on certificates, and er 48, Acts of 9 requires Physi- to print or type under signature.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 15

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. 133 Cliff Avenue St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

2 FULL NAME Belinda Yvonne Waldron
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. 133 Cliff Avenue St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 18 years months days. In place of residence 18 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 5 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from DEC 15, 1956, to FEB 5, 1962
I last saw he alive on FEB 5, 1962, death is said to have occurred on the date stated above, at 1:30 P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: 16 hrs
Due To
(b) GENERAL ARTERIOSCLEROSIS — 2 YRS.
Due To
(c)
OTHER SIGNIFICANT CONDITIONS NONE

Was autopsy performed? No
What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Myron N. King, M. D.
MYRON N. KING M.D.
(PRINT OR TYPE SIGNATURE)
(Address) 222 Pleasant St. Winthrop Date 2/7 1962

6 HolyHood Cemetery, Brookline
Place of Burial or Cremation (City or Town)
DATE OF BURIAL February 8, 1962

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh
ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed FEB 7 1962
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female
9 COLOR white
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) divorced

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Harold Evans
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 60 Years 9 Months 10 Days — If under 24 hours Hours Minutes

13 Usual Occupation: housework
(Kind of work done during most of working life)

14 Industry or Business: own home

15 Social Security No. none

16 BIRTHPLACE (City) New York City
(State or country) New York

PARENTS
17 NAME OF FATHER Charles Henry Waldron
18 BIRTHPLACE OF FATHER (City) Utica
(State or country) New York
19 MAIDEN NAME OF MOTHER Florence Victoria Nolan
20 BIRTHPLACE OF MOTHER (City) New York City
(State or country) New York

21 Informant Mrs. Wallace L. Fabyan
(Address) 133 Cliff Ave. Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Mass. Harold E. Freeman
(Signature of Agent of Board of Health or other)
Health Officer 2/7/62
(Official Designation) (Date of Issue of Permit)

50-928145

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

RM R-301

STRUCTIONS FOR DAL CERTIFICATE

In giving UE OF DEATH

not enter re than one se for each), (b) and (c)

does not mean ode of dying, s heart failure, , etc. It means ease, or compli- which caused

tions, if any, gave rise to cause (a), g the under- cause last.

ditions contrib- death but not to the terminal condition given

e:- Chapter 137, of 1954 requires icians to print or the cause or s of death on certificates, and ter 48, Acts of requires Physi- to print or type under signature.

C.

T

61-930213

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 16

X

1 PLACE OF DEATH: SUFFOLK (County); WINTHROP (City or Town); No. 10 UNDINE AVE St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME LEWIS P MURPHY (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO.

(a) Residence, No. 10 UNDINE AVE St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 9 years months days. In place of residence 9 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February (Month) 7, (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from March 17, 1960, to Feb. 7, 1962

I last saw him alive on Feb. 5, 1962, death is said to have occurred on the date stated above, at 2:50 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Arteriosclerotic & hypertensive heart disease	1 yr.
Due To (b) Generalized arteriosclerosis	2 yrs.
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Carcinoma of pharynx	3 yrs.

...tions, if any, ...gave rise to ... cause (a), ...g the under- ... cause last.

...ditions contrib- ... death but not ... to the terminal ... condition given

Was autopsy performed? no.
What test confirmed diagnosis? Clinical & laboratory

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) M. Trauhstein, Jr. M. D.
M. Trauhstein, Jr., M.D. (Print or Type Name)
(Address) 73 Bartlett Rd. Winthrop 52, Mass. Date Feb. 8, 1962

6 ST MARY DORCHESTER
Place of Burial or Cremation (City or Town)
DATE OF BURIAL FEB 10 1962

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY
ADDRESS WINTHROP

Received and filed FEB 8 1962 (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 CITIZEN OF U.S.	11
MALE	WHITE	YES ☒ NO ☐	SINGLE ☐ MARRIED ☒ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐

11a If married, widowed, or divorced
HUSBAND of MARY E FARRELL (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

12 DATE OF BIRTH

13 AGE 77 Years Months Days — If under 24 hours Hours Minutes

14 Usual Occupation: PRESS MAN. (Kind of work done during most of working life)

15 Industry or Business: NEWSPAPER

16 Social Security No. 628-07-7788

17 BIRTHPLACE (City) ST JOHN (State or country) N. B.

PARENTS

18 NAME OF FATHER JOHN

19 BIRTHPLACE OF FATHER (City) ST JOHN (State or country) N. B.

20 MAIDEN NAME OF MOTHER MARY COLLINS.

21 BIRTHPLACE OF MOTHER (City) ST JOHN (State or country) N B.

22 Informant MRS MARY FARRELL MURPHY
(Address) 10 UNDINE AVE WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

V.P.

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

M R-305

— MINOR REPAIRS ARE ON ONLY APPROVED BLACK TYPEWRITER RIBBON —
THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-3-61-930213

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(City or town making return)

Registered No. 205 17

1 PLACE OF DEATH
Middlesex (County)
Cambridge (City or Town)
No. En route to Cambridge City Hosp. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Albert Geffin
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No. 7 Myrtle Avenue St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months 1 days. In place of residence ....years....months 2 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 12, 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Arteriosclerotic Heart Disease with hypertension and auricular fibrillation
Sudden Death.

5 Accident, suicide, or homicide (specify)
Date and hour of injury ....19....
If accidental, was injury causally related to the death?
Where did Injury occur? (City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)
Manner of Injury (How did injury occur?)
Nature of Injury no
While at work? Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased?
If so, specify David C. Dow

(Signed) David C. Dow, M. D.
(Address) Cambridge, Mass. Date 2-12 19 62

7 Place of Burial or Cremation Arlington Cem. (City or Town)
DATE OF BURIAL Feb. 13, 19 62

8 NAME OF FUNERAL DIRECTOR Torr Funeral Service
ADDRESS Chelsea, Mass.

Received and filed ....19....
MAR 5 1962
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 CITIZEN OF U.S.	12 SINGLE ☐ MARRIED ☒ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐
Male	White	YES ☐ NO ☐	

12a If married, widowed, or divorced
HUSBAND of Rose Kissen
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

13 DATE OF BIRTH

14 AGE 68 Years....Months....Days If under 24 hours ....Hours....Minutes

15 Usual Occupation: Stitcher
(Kind of work done during most of working life)

16 Industry or Business: Upholstering

17 Social Security No. 002-09-6455

18 BIRTHPLACE (City) (State or country) Russia

PARENTS
19 NAME OF FATHER Isaac Geffin
20 BIRTHPLACE OF FATHER (City) (State or country) Russia
21 MAIDEN NAME OF MOTHER Cannot be learned
22 BIRTHPLACE OF MOTHER (City) (State or country) Russia

23 Informant Rose Geffin
(Address) Myrtle Ave. Winthrop, Mass.

A TRUE COPY
ATTEST: Thomas M. McNamara
(Registrar of City or Town where death occurred)

DATE FILED Feb. 13, 19 62

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

RM R-301A

ISTRUCTIONS FOR IAL CERTIFICATE

n giving E OF DEATH

not enter re than one ase for each (, (b) and (c)

does not meon ode of dying, heart failure, etc. It meons ase, or compli- which coused

ntions, if ony, gave rise to cause (a), the under- cause lost.

Conditions contrib- deoth but not to the terminol condition given a)

Note :- Chapter 137, of 1954, requires yrians to print or pe the cause or us of death on at certificates, and ter 48, Acts of 59 requires Physi- an to print or type under signature.

1-10-928145

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 18

X

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) I

2 FULL NAME Frank (First Name) A. (Middle Name) Kelly (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. 102 Pleasant St (Usual place of abode) St. Winthrop (If nonresident, give city or town and State)

Length of stay: In place of death ....years 1 months 10 days. In place of residence ....years ....months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH february 13, (Month) (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1962, to Feb. 13, 1962
I last saw him alive on Feb. 12, 1962, death is said to have occurred on the date stated above, at 7.35 Am.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

	INTERVAL BETWEEN ONSET AND DEATH
(a) ~~Cirrhous of Liver~~	
Due To (b) Cirrhosis of Liver	3 Mos.
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Diabetes Mellitus	3 years

Was autopsy performed? No
What test confirmed diagnosis? Clinical Findings

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) John F Collins M.D., M. D.
(PRINT OR TYPE SIGNATURE) John F. Collins, M.D.
(Address) Revere, Mass. Date Feb. 13, 1962

6 Mt. Calvary, Mattapan
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Feb. 16, 1962

7 NAME OF FUNERAL DIRECTOR Stephen C. Higgins
ADDRESS 2 Neponset Ave., Dorchester

Received and filed FEB 14 1962 19....
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX M
9 COLOR White
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Married

10a If married, widowed, or divorced HUSBAND of Regina R. Travers
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 67 Years ....Months ....Days
If under 24 hours ....Hours ....Minutes

13 Usual Occupation: Tunnel Employee, retired
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) Boston
(State or country) Mass.

PARENTS

17 NAME OF FATHER Arsenius Kelly

18 BIRTHPLACE OF FATHER (City) East Boston
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Helen C. Healey

20 BIRTHPLACE OF MOTHER (City) New York
(State or country)

21 Informant Mrs. Regina R. Kelly
(Address) 102 Pleasant St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Ralph C. Swanson
(Signature of Agent of Board of Health or other)
Health Officer 2/14/62
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE ....September 6, 1918....

DATE OF DISCHARGE ....December 11, 1918....

RANK, RATING ...Private....

ORGANIZATION AND OUTFIT ....1st Co., Boston C. A. C. ARMY....

SERVICE NUMBER ....4903214....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-302

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-9-59-926111

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

EVERETT
(City or Town making this return)

Registered No. 19

1 PLACE OF DEATH
Middlesex (County)
Everett (City or Town)
No. Woodlawn Manor Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME George E. Mahoney
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 105 Circuit Road St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months....3....days. In place of residence 30 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February (Month) 13, (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan. 1 19 62 to February 13, 19 62
I last saw him alive on February 13 19 62, death is said to have occurred on the date stated above, at 9:35 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: -
Due To (b) Generalized Arteriosclerosis — 1 year
Due To (c) -
OTHER SIGNIFICANT CONDITIONS -

Was autopsy performed? No
What test confirmed diagnosis? Clinical findings

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) John F. Collins, M. D.
(Address) 27 Bennington St., Revere, Mass. Date Feb. 14 19 62

6 Winthrop Cemetery, Winthrop
Place of Burial or Cremation (City or Town)
DATE OF BURIAL February 16, 19 62

7 NAME OF FUNERAL DIRECTOR O'Maley Funeral Home
ADDRESS Winthrop, Mass.

Received and filed MAR 7 1962 19 62
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Widowed

10a If married, widowed, or divorced
HUSBAND of Anna F. Croak
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 80 Years - Months - Days. If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Dentist
(Kind of work done during most of working life)

14 Industry or Business: --

15 Social Security No. None

16 BIRTHPLACE (City) East Boston
(State or country) Mass.

PARENTS

17 NAME OF FATHER Edward Mahoney

18 BIRTHPLACE OF FATHER (City) -
(State or country) Ireland

19 MAIDEN NAME OF MOTHER Frances A. Walsh

20 BIRTHPLACE OF MOTHER (City) East Boston
(State or country) Mass.

21 Informant Mary G. Mahoney
(Address) 105 Circuit Rd., Winthrop, Mass

A TRUE COPY
ATTEST: John M. Carroll
(Registrar of City or Town where death occurred)
DATE FILED February 16, 19 62

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

M R-301A

TRUCTIONS FOR IL CERTIFICATE

n giving S OF DEATH

d not enter e than one a e for each (a), (b) and (c)

is does not mean de of dying, heart failure, etc. It means ase, or compli- which caused

ncions, if any, e gave rise to cause (a), the under- cause last.

Conditions contrib- death but not to the terminal condition given

te Chapter 137, 1954, requires ns to print or e cause or of death on tificates, and 48, Acts of quires Physi- print or type der signature.

DS-59-925686

The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 20

PLACE OF DEATH

1 Suffolk (County) Chelsea 3-5-62

Winthrop (City or Town)

No. Mayflower Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Louis Goodman (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No. 239 Chestnut St. Chelsea (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 6 years 7 months — days. In place of residence 30 years — months — days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb (Month) 14 (Day) 1962 (Year)

4 I HEREBY CERTIFY That I attended deceased from July, 1955 to Feb 14, 1962, I last saw him alive on Feb. 14, 1962, death is said to have occurred on the date stated above, at 10:30 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Pyelonephritis, bilateral	7yrs
Due To (b)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Arteriosclerosis.	10yrs.

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Charles Liberman, M. D.
CHARLES LIBERMAN
(PRINT OR TYPE SIGNATURE)
(Address) WINTHROP Date 2/14/ 1962

6 Beth Jacob Woburn
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Feb 15 1962

7 NAME OF FUNERAL DIRECTOR Joy Funeral Service Inc
ADDRESS Chelsea

Received and filed FEB 15 1962 19
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male

9 COLOR White

10 ~~SINGLE~~ ~~MARRIED~~ ~~WIDOWED~~ or DIVORCED (write the word) Widowed

10a If married, widowed, or divorced HUSBAND of Mary Krivitsky (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 96 Years — Months — Days. If under 24 hours Hours Minutes

13 Usual Occupation: Tailor (Kind of work done during most of working life)

14 Industry or Business: Tailoring

15 Social Security No. 031-07-7847

16 BIRTHPLACE (City) (State or country) Russia

PARENTS

17 NAME OF FATHER Abraham Goodman

18 BIRTHPLACE OF FATHER (City) (State or country) Russia

19 MAIDEN NAME OF MOTHER C.B.L.

20 BIRTHPLACE OF MOTHER (City) (State or country) Russia

21 Informant Annie Rosenberg
(Address) 239 Chestnut St Chelsea

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph C. Jeremiah
(Signature of Agent of Board of Health or other)

Health Officer 2/15/62
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

M R-301A

INSTRUCTIONS FOR FINAL CERTIFICATE

1 giving S OF DEATH

d not enter n: than one ave for each (a) (b) and (c)

is does not mean nle of dying, heart failure, ns etc. It means lis se, or compli- ns which caused

nditions, if any, ic gave rise to ov cause (a), th the under- ng cause last.

Conditions contrib- t death but not ed the terminal se ondition given

Not - Chapter 137, s 1954, requires rsians to print or e the cause or se of death on th ertificates, and apt 48, Acts of 9, quires Physi- ns print or type ne der signature.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 21

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Nathan H. Feldman
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 58 Campbell Avenue St. Revere, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 28 days. In place of residence 16 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb. 15, 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from January, 1956, to Feb. 15, 1962,
I last saw him alive on Feb 14, 1962, death is said to have occurred on the date stated above, at 1:45 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cancer of Brain — INTERVAL BETWEEN ONSET AND DEATH 6 yrs.

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS None.

Was autopsy performed? No
What test confirmed diagnosis Clinical - Pathological.

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Charles Liberman, M. D.
CHARLES LIBERMAN
(PRINT OR TYPE SIGNATURE)
(Address) WINTHROP, MASS. Date 2/15/ 1962

6 Chevra Tillum of Boston Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 18 1962

7 NAME OF FUNERAL DIRECTOR Paul R. Levine

ADDRESS 470 Harvard St., Brookline

Received and filed Feb. 16, 1962
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male

9 COLOR White

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Married

10a If married, widowed, or divorced HUSBAND of Evelyn Cook
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 48 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Proprietor
(Kind of work done during most of working life)

14 Industry or Business: Hardware Store

15 Social Security No. 034-10-6441

16 BIRTHPLACE (City) Leominster
(State or country) Mass.

PARENTS

17 NAME OF FATHER Morris Feldman

18 BIRTHPLACE OF FATHER (City) Russia
(State or country)

19 MAIDEN NAME OF MOTHER Ida Finkel

20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)

21 Informant Mrs. Evelyn Feldman
(Address) 58 Campbell Ave., Revere

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph Sirian
(Signature of Agent of Board of Health or other)

Health Officer — Feb. 16, 1962
(Official Designation) (Date of Issue of Permit)

928145

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

M R-301A

TRUCTIONS FOR CL CERTIFICATE

giving S OF DEATH

d not enter more than one ate for each a (b) and (c)

does not mean ole of dying, heart failure, etc. It means sse, or compli- which caused

ons, if any, gave rise to cause (a), the under- cause last.

itions contrib- death but not the terminal ondition given

ot - Chapter 137, 1954, requires ians to print or he cause or se of death on certificates, and pt 48, Acts of equires Physi- print or type nder signature.

6-1-928145

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 32

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town); No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Lulu Belle Nott (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO.

(a) Residence. No. 30 Pleasant Park Road St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months 14 days. In place of residence 73 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 18 1962 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from FEBRUARY 6 1962, to FEBRUARY 18, 1962
I last saw him alive on FEBRUARY 18, 1962, death is said to have occurred on the date stated above, at 1:15 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) ACUTE CORONARY INSUFFICIENCY	36 HRS
Due To (b) ARTERIOSCLEROTIC HEART DISEASE	5 YRS
Due To (c) ACUTE MYOCARDIAL INSUFFICIENCY WITH PULMONARY EDEMA	1 WEEK
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? No
What test confirmed diagnosis? EKG - XRAY

5 Was disease or injury in any way related to occupation of deceased? No.
If so, specify

(Signed) Dorothy Chaney Appleton, M. D.
DOROTHY CHENEY APPLETON (PRINT OR TYPE SIGNATURE)
(Address) 19 T Woodside Ave WINTHROP, MASS Date FEB 19 1962

6 Winthrop Cemetery, Winthrop, Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 21, 1962

7 NAME OF FUNERAL DIRECTOR Alfred B Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed FEB 20 1962
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Widowed

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Charles Eugene Nott
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 73 Years 5 Months 4 Days — If under 24 hours ....Hours....Minutes

13 Usual Occupation retired Telephone Operator
(Kind of work done during most of working life)

14 Industry or Business: N.E.Tel &Tel Co.

15 Social Security No. 011-05-0510

16 BIRTHPLACE (City) Winthrop
(State or country) Massachusetts

PARENTS

17 NAME OF FATHER George Dyer

18 BIRTHPLACE OF FATHER (City)
(State or country) Maine

19 MAIDEN NAME OF MOTHER Isabel Webster

20 BIRTHPLACE OF MOTHER (City) Winthrop
(State or country) Massachusetts

21 Informant Mrs. Omar T. Johnson
(Address) 30 Pleasant Park Road, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ruth E. Lorenzini
(Signature of Agent of Board of Health or other)

Health Officer 2/20/62
(Official Designation) (Date of Issue of Permit)

V.B.

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....RECEIVED.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

M R-301A

TRUCTIONS FOR IL CERTIFICATE

1 giving S OF DEATH

d not enter re than one ate for each a (b) and (c)

s does not mean nte of dying, a heart failure, ni etc. It means isse, or compli- s which caused

ons, if any, ic gave rise to e cause (a), in the under- ng cause last.

ditions contrib- death but not the terminal condition given

ot - Chapter 137, s 1954, requires ans to print or e the cause or se of death on th rtificates, and pt 48, Acts of 9, quires Physi- n print or type e der signature.

6-928145

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 23

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Winthrop Convalescent Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Ada Blanche Wrightson
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO.

(a) Residence. No. 11 Nahant Avenue St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 4 years months days. In place of residence 40 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 18 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan. 13, 1962, to Feb. 18, 1962
I last saw her alive on Feb. 18, 1962, death is said to have occurred on the date stated above, at 5:10 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

	INTERVAL BETWEEN ONSET AND DEATH
(a) Arteriosclerotic & hypertensive heart disease	5 yrs
Due To (b) Generalized arteriosclerosis	7 yrs
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? no
What test confirmed diagnosis Clinical & laboratory

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) M. Traunstein, Jr., M. D.
M. Traunstein, Jr., M. D.
(PRINT OR TYPE SIGNATURE)
(Address) 73 Bartlett Rd., Winthrop 52, Mass. Date Feb. 20, 1962

6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL February 20, 1962

7 NAME OF FUNERAL DIRECTOR Cedric B. Marsh
ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed FEB 20 1962
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female
9 COLOR White
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Married

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Sydney John Wrightson
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 83 Years 7 Months 16 Days
If under 24 hours Hours Minutes

13 Usual Occupation retired Fur Seamstress
(Kind of work done during most of working life)

14 Industry or Business: retail Dept. Store

15 Social Security No. 032-20-0065

16 BIRTHPLACE (City) London
(State or country) England

PARENTS

17 NAME OF FATHER Arthur Smith

18 BIRTHPLACE OF FATHER (City) London
(State or country) England

19 MAIDEN NAME OF MOTHER Mirriam Smith

20 BIRTHPLACE OF MOTHER (City) London
(State or country) England

21 Informant Reginald J. Wrightson
(Address) 11 Nahant Avenue, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
(Signature of Agent of Board of Health or other)
Health Officer 2/20/62
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

M R-301A

NSTRUCTIONS FOR C. CERTIFICATE

. giving S OF DEATH

do not enter nc than one a: for each a (b) and (c)

is does not mean nse of dying, a heart failure, etc. It means ise, or compli- which caused

ndons, if any, ictgave rise to ue cause (a), in the under- g cause last.

Conditions contrib- to death but not d the terminal condition given

Chapter 137, of 954, requires is to print or cause or f death on ertificates, and ter 48, Acts of quires Physi- to print or type ter signature.

M-59-925686

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 21

1 PLACE OF DEATH
SUFFOLK (County)
WINTHROP (City or Town)
No. 104 HIGHLAND AVE. St. MOUNTS CONVALESCENT HOME (If death occurred in a hospital or institution, give its NAME instead of street and number)

Chelsea N/S

PHYSICIAN — IMPORTANT

2 FULL NAME MARION L. (HOBART) THOMPSON (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 12 CLARK AVE. CHELSEA St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months. 3 days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb (Month) 19 (Day), 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to....., 19.....

I last saw h.....alive on ....., 19....., death is said to have occurred on the date stated above, at 8:30 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death apparently due to acute

Due To (b) coronary occlusion, due to ~~[illegible]~~ arteriosclerotic heart

Due To (c) disease. Diabetes mellitus a known significant condition.

OTHER SIGNIFICANT CONDITIONS To Winthrop Board of Health

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? Charles Lieberman, MD

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) Charles Lieberman, M. D.

CHARLES LIBERMAN (PRINT OR TYPE SIGNATURE)

(Address) Winthrop Mass Date 2/19/ 1962

6 WOODLAWN EVERETT
Place of Burial or Cremation (City or Town)

DATE OF BURIAL FEB. 21, 1962

7 NAME OF FUNERAL DIRECTOR Wendell W. Dykeman

ADDRESS 23 Cary Ave Chelsea

Received and filed ..... 19.....

FEB 19 1962 (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: FEMALE

9 COLOR: WHITE

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): DIVORCED

10a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of A. PAUL THOMPSON (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 66 Years.....Months.....Days | If under 24 hours .....Hours.....Minutes

13 Usual Occupation: CLERK (Kind of work done during most of working life)

14 Industry or Business: INTERNAL REVENUE SERVICE

15 Social Security No. 047-14-1000

16 BIRTHPLACE (City) CHELSEA (State or country) MASS

PARENTS

17 NAME OF FATHER WEBSTER L. HOBART

18 BIRTHPLACE OF FATHER (City) CHELSEA (State or country) MASS

19 MAIDEN NAME OF MOTHER AMELIA G. LESLIE

20 BIRTHPLACE OF MOTHER (City) PICTOU (State or country) N.S.

21 Informant JOAN LESLIE POLLARD
(Address) 12 CLARK AVE CHELSEA

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sieberman Jr. (Signature of Agent of Board of Health or other)

Health Officer (Official Designation) 2/19/62 (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

M R-301A

Shirley ST

NSTRUCTIONS FOR CATE CERTIFICATE

giving E OF DEATH

ot enter than one for each a, (b) and (c)

oes not mean se of dying, heart failure, etc. It means se, or compli- which caused

ms, if any, rave rise to cause (a), the under- cause last.

ditions contrib- death but not the terminal ndition given

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5-6928145

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 25

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. Winthrop Convalesent Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME William C Nicol (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 142 Pleasant Street St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death years 5 months days. In place of residence 32 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb. (Month) 20 (Day) 1962. (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec, 1956, to February 20, 1962

I last saw him alive on Feb. 18, 1962, death is said to have occurred on the date stated above, at 2:00 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Occlusion, acute — INTERVAL BETWEEN ONSET AND DEATH: ½ hour

Due To (b) Arteriosclerotic Heart Disease — 6 yrs.

Due To (c)

OTHER SIGNIFICANT CONDITIONS None.

Was autopsy performed? No

What test confirmed diagnosis Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Charles Liberman, M. D
CHARLES LIBERMAN
(PRINT OR TYPE SIGNATURE)

(Address) WINTHROP, MASS Date 2/20/1962

6 Woodlawn Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Feb. 23 1962

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass

Received and filed FEB 21 1962 19
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male

9 COLOR White

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Married

10a If married, widowed, or divorced
HUSBAND of Susan Card
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 80 Years 8 Months Days — If under 24 hours Hours Minutes

13 Usual Occupation: Electrican
(Kind of work done during most of working life)

14 Industry or Business: Contractor

15 Social Security No. 010-07-1890

16 BIRTHPLACE (City) (State or country) Scotland

PARENTS

17 NAME OF FATHER James Nicol

18 BIRTHPLACE OF FATHER (City) (State or country) Scotland

19 MAIDEN NAME OF MOTHER Manuilla Colledge

20 BIRTHPLACE OF MOTHER (City) (State or country) Scotland

21 Informant Manuilla Moore
(Address) North Reading, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph Sisson
(Signature of Agent of Board of Health or other)

Health Officer Feb. 21, 1962
(Official Designation) (Date of Issue of Permit)

(N B)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

RECEIVED

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

M R-301A

ERUCTIONS FOR CERTIFICATE

giving OF DEATH

ot enter than one for each (b) and (c)

oes not mean of dying, heart failure, etc. It means e, or compli- which caused

ns, if any, ave rise to cause (a), the under- cause last.

ions contrib- death but not the terminal ndition given

te Chapter 137, 1954, requires ns to print or e cause or of death on rtificates, and te 48, Acts of quires Physi- print or type ller signature.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 26

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Julius (First Name) Lank (Middle Name) Lank (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 11 Pearl Avenue St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months....1....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb. (Month) 22 (Day) 1962 (Year)

4 I HEREBY CERTIFY That I attended deceased from Sept. 1, 1950, to Feb. 22, 1962
I last saw him alive on Feb. 22, 1962, death is said to have occurred on the date stated above, at 1:15 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Cerebral Hemorrhage	1wk.
Due To (b) Hypertension	10yrs.
Due To (c) Arterio sclerosis	4yrs.
OTHER SIGNIFICANT CONDITIONS Residual of Cerebral Hemorrhage	5yrs.

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Charles Liberman, M. D
CHARLES LIBERMAN
(PRINT OR TYPE SIGNATURE)
(Address) WINTHROP, MASS Date 2/22/1962

6 Tiferath Israel of Winthrop Everett
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Feb 23 1962

7 NAME OF FUNERAL DIRECTOR Joe Funeral Service Inc
ADDRESS Chelsea

Received and filed FEB 23 1962 19.....
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male
9 COLOR White
10 ~~SINGLE~~ MARRIED ~~WIDOWED~~ ~~or DIVORCED~~ (write the word) Married

10a If married, widowed, or divorced HUSBAND of Mazie Brenner
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 59 Years — Months — Days
If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Machine Inspector
(Kind of work done during most of working life)

14 Industry or Business: General Electric Co.

15 Social Security No. 001-65-8378

16 BIRTHPLACE (City) (State or country) Chelsea Mass

PARENTS
17 NAME OF FATHER Barnett Lank
18 BIRTHPLACE OF FATHER (City) (State or country) Russia
19 MAIDEN NAME OF MOTHER Bessie (CAZ)
20 BIRTHPLACE OF MOTHER (City) (State or country) Russia

21 Informant Maxa Lank
(Address) 11 Pearl Ave Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Walter J. Sullivan
(Signature of Agent of Board of Health or other)
Registrar
(Official Designation) (Date of Issue of Permit) 2/23/62

V.B.V

3-6028145

SPACE FOR ADDITIONAL INFORMATION.....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING.....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R-303

N B.—WRITE PLAINLY, WITH INK. Physicians, MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-3-61-930213

X

PLACE OF DEATH

1 SUFFOLK (County)

WINTHROP (City or Town)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 27

No. 220 Veterans Road St. {(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME SAMUEL (First Name) NESSELLE (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
{(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 30 Cutler Street St. Winthrop, Massachusetts
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 25 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 22, 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

CORONARY-ARTERY DISEASE

5 Accident, suicide, or homicide (specify) .....

Date and hour of injury .....19.....

IF ACCIDENTAL, was injury causally related to the death? .....

Where did Injury occur? .....
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? .....
(Specify type of place)

Manner of Injury .....
(How did injury occur?)

Nature of Injury .....

While at work? .....Was autopsy performed? NO

6 Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) Leonard Atkins M. D.

Leonard Atkins M.D.
(Print or Type Name)

(Address) 25 Shattuck St. Date 2/22 19 62

7 Beth Joseph #3, Woburn
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL February 23, 19 62

8 NAME OF FUNERAL DIRECTOR Benjamin Birnbach

ADDRESS 10 Washington St. Dorch.

Received and filed FEB 23 1962 19.....

A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 CITIZEN OF U.S.	12
Male	White	YES ☒ NO ☐	SINGLE ☐ MARRIED ☒ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐

12a If married, widowed, or divorced
HUSBAND of Anne Springer
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

13 DATE OF BIRTH

14 AGE 56 Years.....Months.....Days | If under 24 hours .....Hours .....Minutes

15 Usual Occupation: Plumber
(Kind of work done during most of working life)

16 Industry or Business: Self Employed

17 Social Security No. 010-05-7554

18 BIRTHPLACE (City) (State or country) Boston, Mass.

PARENTS

19 NAME OF FATHER David Nesselle

20 BIRTHPLACE OF FATHER (City) (State or country) Russia

21 MAIDEN NAME OF MOTHER Gertrude Medson

22 BIRTHPLACE OF MOTHER (City) (State or country) Russia

23 Informant Anne Nesselle
(Address) 30 Cutler St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Raymond C. Williams
(Signature of Agent of Board of Health or other)

Health Officer 2/23/62
(Official Designation) (Date of Issue of Permit)

MEDICAL

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

M R-301A

IRS.

RUCTIONS FOR CERTIFICATE

I giving OF DEATH

ot enter than one for each (b) and (c)

oes not mean of dying, heart failure, etc. It means e, or compli- which caused

ons, if any, ave rise to cause (a), the under- ause last.

ntions contrib- eath but not the terminal ndition given

ote Chapter 137, 1954, requires sicians to print or e cause or es of death on h certificates, and pter 48, Acts of , requires Physi- s to print or type er signature.

6-6928145

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 98

1 PLACE OF DEATH
Suffolk (County) Boston 9-2-3
Winthrop (City or Town)
No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) no

2 FULL NAME Female (First Name) Bagnera (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 160 Webster St (Usual place of abode) St. East Boston (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 24, 1962 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb 24, 1962, to Feb. 24, 1962
I last saw h. en live on Feb. 24, 1962; death is said to have occurred on the date stated above, at 8:50A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Prematurity
Due To
(b) Premature separation of
Due To
(c) Placenta

INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No
What test confirmed diagnosis? None

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) D. Thomas Staffier, M. D
D. Thomas Staffier (PRINT OR TYPE SIGNATURE)
(Address) 21 Breed St Date Feb. 24 1962

6 Place of Burial or Cremation Holy Cross Cemetery Malden (City or Town)
DATE OF BURIAL Feb. 27, 1962

7 NAME OF FUNERAL DIRECTOR Vincent Rapino
ADDRESS 9 Chelsea St., East Boston, Mass.

Received and filed 2-27 1962
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX F
9 COLOR white
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) single

10a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE.....Years.....Months.....Days
If under 24 hours 4 Hours — Minutes

13 Usual Occupation: none
(Kind of work done during most of working life)

14 Industry or Business: none

15 Social Security No. none

16 BIRTHPLACE (City) (State or country) Winthrop, Mass.

PARENTS
17 NAME OF FATHER Edward Bagnera
18 BIRTHPLACE OF FATHER (City) (State or country) Winthrop, Mass.
19 MAIDEN NAME OF MOTHER Margaret DiNocco
20 BIRTHPLACE OF MOTHER (City) (State or country) Boston, Mass.

21 Informant Edward Bagnera (father)
(Address) 160 Webster St., E. Boston, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
[illegible] (Signature of Agent of Board of Health or other)
Health Officer (Official Designation) 2/27/62 (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 203

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

Revere 3-5-62 N

No. Winthrop Community Hospital St. {(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Lee (First Name) Green (Middle Name) (Litt)le (Last Name) {(Was deceased a U. S. War Veteran, if so specify WAR) No

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 88 Crescent Ave St. Revere
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months 22 days. In place of residence 8 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February (Month) 24, (Day) 1962 (Year)

4 I HEREBY CERTIFY That I attended deceased from Feb. 2, 1962, to Feb. 24, 1962

I last saw h.. alive on Feb. 24, 1962, death is said to have occurred on the date stated above, at 11:10 P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinomatosis

Due To (b) Carcinoma of ovary (bilateral)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH weeks months

Was autopsy performed? No

What test confirmed diagnosis? Biopsy

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Joseph Gregoire, M. D
(PRINT OR TYPE SIGNATURE) Joseph Gregoire

(Address) 194 Washington St Date 2/25 1962

6 Woodlawn Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Feb. 28, 1962

7 NAME OF FUNERAL DIRECTOR Arthur S. Porcella

ADDRESS 876 Winthrop Ave, Revere

Received and filed MAR 5 1962 19.....

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female

9 COLOR White

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Married

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Edward Green
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 38 Years 9 Months 1 Days | If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: None

15 Social Security No. 371-14-8608

16 BIRTHPLACE (City) Unknown
(State or country)

PARENTS

17 NAME OF FATHER (Unknown) Litt

18 BIRTHPLACE OF FATHER (City) Cannot be learned
(State or country)

19 MAIDEN NAME OF MOTHER Cannot be learned

20 BIRTHPLACE OF MOTHER (City) Cannot be learned
(State or country)

21 Informant Charles Doty
(Address) 88 Crescent Ave, Revere

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph C. Sweeney
(Signature of Agent of Board of Health or other)

Health Officer 2/26/62
(Official Designation) (Date of Issue of Permit)

1 R-301A

RUCTIONS FOR CERTIFICATE

I giving OF DEATH

ot enter than one for each (b) and (c)

es not mean of dying, heart failure, etc. It means see, or compli- which caused

ns, if any, ave rise to cause (a), the under- cause last.

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te Chapter 137, 1954, requires ns to print or e cause or of death on tificates, and te 48, Acts of quires Physi- print or type ler signature.

6-928145

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

ORM R-302

THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-9-59-926111

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Registered No. 30

1 PLACE OF DEATH: Suffolk (County); Revere (City or Town); No. Grover Manor Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number)

Revere (City or Town making this return)

2 FULL NAME: Margaret Placco (Buckley)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 21 Nevada St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 6 years 3 months 24 days. In place of residence 60 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: February (Month) 24, (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1955 to Feb. 24, 1962. I last saw him alive on Feb. 24, 1962 death is said to have occurred on the date stated above, at 11:30A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Uremia	3days
Due To (b) Myocarditis	6mo.
Due To (c) Chronic Nephritis	2yrs.
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? No
What test confirmed diagnosis? Clinical Signs

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) James F. Burns M. D.
(Address) Everett Date 2/25/ 1962

6 Winthrop Cemetery Winthrop
Place of Burial or Cremation (City or Town)
DATE OF BURIAL February 27, 1962

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
ADDRESS Winthrop, Mass.

Received and filed 3-5-62 19

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Widowed

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Joseph Placco
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 87 Years Months Days — If under 24 hours Hours Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No.

16 BIRTHPLACE (City) (State or country) Ireland

PARENTS

17 NAME OF FATHER Michael Buckley

18 BIRTHPLACE OF FATHER (City) (State or country) Ireland

19 MAIDEN NAME OF MOTHER Ellen Sweeney

20 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

21 Informant Helen Wyke
(Address) 21 Nevada St., Winthrop

A TRUE COPY
ATTEST:
(Registrar of City or Town where death occurred)
DATE FILED February 26, 1962

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

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R-301A

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The Commonwealth of Massachusetts — COPY OF TOWN

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

31

Registered No. 10316

PLACE OF DEATH

1 Suffolk (County)

Boston (City or Town)

No. Beth Israel Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Matilda Louie (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No.

(a) Residence, No. 85 Sagamore Avenue St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..years..months. ½ hour days. In place of residence 5 years..months..days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 1 (Month) 9 (Day) 62 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 1/9, 1962, to 1/9, 1962
I last saw her alive on 1/9, 1962, death is said to have occurred on the date stated above, at 10:22 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH 2 hrs

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) Louis Schneiderman, M. D.
Louis Schneiderman
(PRINT OR TYPE SIGNATURE)

(Address) 330 Brookline Ave Boston Date 1/9, 1962

6 Place of Burial or Cremation Winthrop Cem. (City or Town) Everett

DATE OF BURIAL January 11, 1962

7 NAME OF FUNERAL DIRECTOR Arnold Golov

ADDRESS 1668 Beacon St. Brookline

Received and filed JAN 22 1962 19..
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female

9 COLOR White

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word) Single

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 65 Years 3 Months 14 Days — If under 24 hours ..Hours..Minutes

13 Usual Occupation: Clerk.
(Kind of work done during most of working life)

14 Industry or Business: Boston Hay + Grain.

15 Social Security No. 023-16-0764

16 BIRTHPLACE (City) Boston
(State or country) Mass

PARENTS

17 NAME OF FATHER Moses Lourie

18 BIRTHPLACE OF FATHER (City) Russia
(State or country)

19 MAIDEN NAME OF MOTHER Lena Band

20 BIRTHPLACE OF MOTHER (City) Russia.
(State or country)

21 Informant Morris Segan
(Address) 85 Sagamore Ave Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

J. Donato
(Signature of Agent of Board of Health or other)

5346, 1-11-62
(Official Designation) (Date of Issue of Permit)

T V.L.V

VS-3

CERTIFICATE OF DEATH

STATE FILE NO. 32

STATE OF MAINE DEPARTMENT OF HEALTH AND WELFARE X - [illegible]

PLACE OF DEATH AND USUAL RESIDENCE

1. PLACE OF DEATH
   a. COUNTY: Kennebec
   b. CITY, TOWN, OR LOCATION: Gardiner
   c. LENGTH OF STAY IN 1b: 45 minutes
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Gardiner Paper Mill

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
   a. STATE: Mass.
   b. COUNTY: Suffolk
   c. CITY, TOWN, OR LOCATION: Winthrop
   d. STREET ADDRESS: 93 Cliff Ave.
   e. IS RESIDENCE ON A FARM? YES ☐ NO X

DECEDENT'S PERSONAL DATA

3a. NAME OF DECEASED–First Name: Lalava
3b. Middle Name: T.
3c. Last Name: Miller
4. DATE OF DEATH (Month, Day, Year): Jan. 11, 1962
5. SEX: Male
6. COLOR OR RACE: White
7. Married X Never Married Widowed Divorced
8. DATE OF BIRTH: June 26, 1907
9. AGE (In years last birthday): 54 — If under 1 year: Mos. Days; If under 24 hrs.: Hrs. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Hampden, Maine
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Leslie E. Miller
14. MOTHER'S MAIDEN NAME: Lou Stella Taylor
15. NAME OF SPOUSE (if married): Adele Lurvey Miller
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No — (If yes, give war or dates of service):
17. SOC. SECURITY NO.: 008-03-2640
18. INFORMANT: Adele L. Miller, 93 Cliff Ave., Winthrop, Mass.

CAUSE OF DEATH

19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) [illegible] — INTERVAL BETWEEN ONSET AND DEATH [illegible]

4260

Conditions, if any, which gave rise to above cause (a) stating the underlying cause last.

DUE TO (b) [illegible]

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS contributing to death but not related to the terminal disease condition given in Part I a

20. WAS AUTOPSY PERFORMED? YES NO

DEATH DUE TO EXTERNAL VIOLENCE

21a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 19.)
21c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21f. CITY, TOWN, OR LOCATION COUNTY STATE

5 - 1962

PHYSICIAN'S OR MEDICAL EXAMINER'S CERTIFICATION

22a. MEDICAL EXAMINER: I hereby certify that death occurred at the time and from the causes stated above, and that I held an (investigation) (autopsy) on the remains of the deceased as required by law.

22b. PHYSICIAN: I hereby certify that I attended this deceased from [illegible] to [illegible] and last saw him alive on [illegible] at [illegible] m. on the date and from the [illegible] state [illegible]

23a. SIGNATURE [illegible] (Degree or title)
23b. ADDRESS [illegible]
23c. DATE SIGNED [illegible]

FUNERAL DIRECTOR AND REGISTRAR

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 1/14/62
24c. NAME OF CEMETERY OR CREMATORY: Locust Grove Toomb
24d. LOCATION (City, town, or county) (State): Hampden, Me.
25. FUNERAL DIRECTOR: Brookings & Smith — ADDRESS: Bangor, Me.
26. DATE RECD. BY LOCAL REG.: 1-11-62
27. REGISTRAR'S SIGNATURE: [illegible]

NOT POSTED 1962

H.B.

Winthrop

FORM R-302

THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-9-59-926111

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Chelsea
(City or Town making the return)

Registered No. 15 33

1 PLACE OF DEATH

Suffolk (County)

Chelsea (City or Town)

No. Chelsea Memorial Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Helen M. Dunn
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR,

(a) Residence. No. 10 Prospect Ave. / Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death - years - months 2 days. In place of residence 15 years - months - days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Jan. 12, 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan. 11, 1962, to Jan. 12, 1962

I last saw her alive on Jan. 12, 1962, death is said to have occurred on the date stated above, at 10:05 A. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Congestive heart failure

Due To (b) Myocardial infarction

Due To (c)

OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? none
What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Salvatore A. DeLuca, M. D.
(Address) 550 Park Ave. Revere Date 1/12/62, 19

6 St. Josephs Cem., W. Roxbury
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Jan. 15, 1962, 19

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.
ADDRESS 917 Bennington St. E. Boston

Received and filed MAR 13 1962, 19
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female

9 COLOR White

10 SINGLE, MARRIED, WIDOWED, or DIVORCED (write the word) Widowed

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of John J. Dunn
(Husband's name in full)
Date of birth June 3, 1881

11 IF STILLBORN, enter that fact here.

12 AGE 80 Years 7 Months 9 Days
If under 24 hours Hours Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: at home

15 Social Security No. none

16 BIRTHPLACE (City) (State or country) Ireland

PARENTS

17 NAME OF FATHER John Coughlin

18 BIRTHPLACE OF FATHER (City) (State or country) Ireland

19 MAIDEN NAME OF MOTHER Mary Hallisey

20 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

21 Informant Mrs. Rita Cullinane-dau.
(Address) 10 Prospect Ave., Winthrop

A TRUE COPY
ATTEST: Joseph A. Tyrrell
(Registrar of City or Town where death occurred)

DATE FILED Jan. 12, 1962, 19

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

R-301

FUNCTIONS OF CERTIFICATE

Leaving DATE OF DEATH

enter an one for each (d) and (e)

do not mean cause of dying, but failure, etc. It means cause or complications which caused death

if any, gave rise to cause (a), underline last.

conditions contributed but not to terminal condition given

chapter 137, § 14 requires clearly to print or the cause or death on certificates, and Acts of requires Physician to print or type and signature.

AR 16 1962

SI-9213

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT - OF - TOWN

To be filed for burial permit with Board of Health or its Agent.

34

Registered No. 10618

1 PLACE OF DEATH: SUFFOLK (County) ROXBURY (City or Town)

No. JEWISH MEMORIAL HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME SAMUEL MACHOTT (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence No. 215 COURT RD., WINTHROP St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years 1 months 17 days. In place of residence 1 years ....months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JANUARY 20 1962 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from DECEMBER 5, 1961, to JANUARY 20, 1962
I last saw him alive on JANUARY 20, 1962, death is said to have occurred on the date stated above, at 11:50 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) BRONCHOPNEUMONIA

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS BRONCHOGENIC CARCINOMA WITH METASTASIS

INTERVAL BETWEEN ONSET AND DEATH: DAYS ; MONTHS

Was autopsy performed? YES
What test confirmed diagnosis? CLINICAL, AUTOPSY

5 Was disease or injury in any way related to occupation of deceased? ....
If so, specify ....

(Signed) Albert Shemtob, M. D.
ALBERT SHEMTOB (Print or Type Name)
(Address) JEWISH MEMORIAL HOSPITAL Date JANUARY 20 1962

6 Place of Burial or Cremation: Sharon Memorial Park (City or Town) Sharon
DATE OF BURIAL January 21 1962

7 NAME OF FUNERAL DIRECTOR Arnold Golov
ADDRESS 1668 Beacon St Brookline

Received and filed JAN 23 1962
Charles H. Mackay (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 CITIZEN OF U.S.	11 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN
Male	White	YES ☒ NO ☐	

11a If married, widowed, or divorced, HUSBAND of Mary Hirshovitz (Give maiden name of wife in full)
(or) WIFE of .... (Husband's name in full)

12 DATE OF BIRTH March 24, 1890

13 AGE 71 Years 9 Months 27 Days — If under 24 hours ....Hours ....Minutes

14 Usual Occupation: Hardware Dealer (Kind of work done during most of working life)

15 Industry or Business: Retired

16 Social Security No. 014-12-9919

17 BIRTHPLACE (City) (State or country) New York

PARENTS

18 NAME OF FATHER Hyman MacHott

19 BIRTHPLACE OF FATHER (City) (State or country) Russia

20 MAIDEN NAME OF MOTHER Bessie C B L

21 BIRTHPLACE OF MOTHER (City) (State or country) Russia

22 Informant Hyman MacHott
(Address) 215 Court Rd Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

22738 (Official Designation) 1/21/62 (Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

RECEIVED

MAR 16 1962 AM

R-301A

TRICTIONS
OR
ATE CERTIFICATE

living
OF DEATH

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use (a),
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use last.

ditions contrib-
death but not
to the terminal
condition given

-4

hapter 137,
of 54, requires
cian to print or
the cause or
of death on
certificates, and
ter 3, Acts of
requires Physi-
to print or type
name signature.

R5 - 1962

60-51145

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT - OF - TOWN

To be filed for burial permit with Board of Health or its Agent.

35

Registered No. 01080.

1 PLACE OF DEATH

Suffolk (County)

Boston (City or Town)

No. New England Center Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Samuel (First Name) (Middle Name) Tanger (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No. 17 Cottage Ave., Winthrop, Mass. St. Winthrop Mass. (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death years 2 months 12 days. In place of residence 10 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January (Month) 31 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from November 20, 1961, to January 31, 1962.

I last saw him alive on January 31, 1962, death is said to have occurred on the date stated above, at 7:35 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CARDIA RESPIRATORY FAILURE

Due To (b) METASTATIC CARCINOMA OF RECTUM

Due To (c)

OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH — MONTHS

Was autopsy performed? NO

What test confirmed diagnosis? BIOPSY

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signed) Howard Morse Gardner M. D.
HOWARD MORSE GARDNER (PRINT OR TYPE SIGNATURE)

(Address) NECH Date 1/31/1962

6 Sharon Memorial park Sharon
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 1 1962

7 NAME OF FUNERAL DIRECTOR Arnold Golov

ADDRESS 1668 Beacon St. Brookline

Received and filed FEB 2 1962 19

Charles E. Mackie (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male

9 COLOR White

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word) Married

10a If married, widowed, or divorced
HUSBAND of Celia Liebman
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 71 Years Months Days

If under 24 hours Hours Minutes

13 Usual Occupation: Manufacturer
(Kind of work done during most of working life)

14 Industry or Business: Retired

15 Social Security No. 025 18 4818

16 BIRTHPLACE (City) New York City
(State or country) N.Y.

PARENTS

17 NAME OF FATHER Abraham Tanger

18 BIRTHPLACE OF FATHER (City)
(State or country) Russia

19 MAIDEN NAME OF MOTHER Tobe Cohen

20 BIRTHPLACE OF MOTHER (City)
(State or country) Russia

21 Informant Rita Rubin
(Address) 118 Bainbridge St. Malden

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

R. J. Rugerson Jr.
(Signature of Agent of Board of Health or other)

A 5657 2/1/62
(Official Designation) (Date of Issue of Permit)

IN

T V.B.V

A TRUE COPY ATTEST

Charles H. Mackie

City Registrar

RECEIVED

APR 5 1962 PM

HI R-303

N. B.—WRITE PLAINLY WITH INKPRINT. BLANKS ... should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

SOM-3-61-90213

OUT - OF - TOWN

36

PLACE OF DEATH

1 SUFFOLK (County)

BOSTON (City or Town)

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 01230

No. ..... St. En route to Massachusetts General Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME HARRIET (First Name) RUNCIE (Middle Name) (Doig) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, (if so specify WAR) .....

(a) Residence. No. 92 Marshall Street, St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 42 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February (Month) 3, (Day) 1962 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Coronary artery disease.
Acute myocardial infarction.

5 Accident, suicide, or homicide (specify) .....

Date and hour of injury ..... 19.....

IF ACCIDENTAL, was injury causally related to the death? .....

Where did Injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)

Manner of Injury ..... (How did injury occur?)

Nature of Injury .....

While at work? ..... Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) Michael A. Luongo, M. D.

Michael A. Luongo, M.D.
(Print or Type Name)

(Address) Boston Date 2/3 19 62

7 Winthrop Place of Burial, or Cremation. Winthrop (City or Town)

DATE OF BURIAL Feb 6 19 62

8 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass.

Received and filed FEB 7 1962 19

A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 CITIZEN OF U.S.	12 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN
Female	White	YES ☐ NO ☐	☐ ☐ ☐ ☐ ☐

12a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of John ... Runcie (Husband's name in full)

13 DATE OF BIRTH 11/15/80

14 AGE 61 Years 1 Months 18 Days If under 24 hours ..... Hours ..... Minutes

15 Usual Occupation: Housewife (Kind of work done during most of working life)

16 Industry or Business: at home

17 Social Security No. None

18 BIRTHPLACE (City) (State or country) Scotland

PARENTS

19 NAME OF FATHER Andrew Doig

20 BIRTHPLACE OF FATHER (City) (State or country) Scotland

21 MAIDEN NAME OF MOTHER Jane Gray

22 BIRTHPLACE OF MOTHER (City) (State or country) Scotland

23 Informant John Runcie
(Address) East Hampstead N.H.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued.

Jacqueline Coats
(Signature of Agent or Board of Health or other)

5-10-94 2/15/63
(Official Designation) (Date of Issue of Permit)

MEDICAL EXAMINER

V.B.V.

20-1

5 - 1962

TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

RECEIVED

APR 5 1962 PM

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT-OF-TOWN

To be filed for burial permit with Board of Health or its Agent. 37

Registered No. 01319

PLACE OF DEATH

1 SUFFOLK (County)

BOSTON (City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL St. {(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Charles H. Howard (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence No 226 Main Street St. Winthrop, Massachusetts
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ___ years ___ months ___ days. In place of residence 25 years ___ months ___ days

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 5 1962 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from January 25, 1962, to February 5, 1962, I last saw him alive on February 5, 1962, death is said to have occurred on the date stated above, at 4:00 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Cerebral Infarction	5 days
Due To (b)	Emboli From heart	5 days
Due To (c)	Rheumatic heart disease	Unk yrs
OTHER SIGNIFICANT CONDITIONS	Pulmonary edema and congestion	5 days

Was autopsy performed? yes

What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased? ____
If so, specify ____

(Signed) Chilloy, M. D.
Charles L. Clay, M.D.
(Print or Type Name)
(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date Feb. 5 1962

6 Holy Cross Malden, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 8 1962

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed FEB 9 1962 19__
Florence M. Mackie
(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 CITIZEN OF U.S.	11 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN
Male	White	YES X NO ☐	MARRIED ☒

11a If married, widowed or divorced
HUSBAND of Veronica M. Gray
(Give maiden name of wife in full)
(or) WIFE of ____
(Husband's name in full)

12 DATE OF BIRTH October 3, 1903

13 AGE 58 Years ___ Months ___ Days | If under 24 hours ___ Hours ___ Minutes

14 Usual Occupation: Truck Driver
(Kind of work done during most of working life)

15 Industry or Business: Trimount Bituminous Products

16 Social Security No. 021-05-2747

17 BIRTHPLACE (City) Boston
(State or country) Massachusetts

PARENTS

18 NAME OF FATHER William A. Howard

19 BIRTHPLACE OF FATHER (City) Melrose
(State or country) Massachusetts

20 MAIDEN NAME OF MOTHER Mary M. Follins

21 BIRTHPLACE OF MOTHER (City) South Boston
(State or country) Massachusetts

22 Informant Veronica M. Howard
(Address) 226 Main St., Winthrop Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

R. P. Dodson
(Signature of Agent of Board of Health or other)

5749 2-7-62
(Official Designation) (Date of Issue of Permit)

V.B.

IN + OUT BOXES

M R-301

S'UCTIONS OR ACCERTIFICATE

aiving E P DEATH

at enter ...nan one ...e or each ...) and (c)

...s not mean ...d of dying, ...art failure, ...c. It means ...) or compli- ...ich caused

...s, if any, ...ge rise to ...use (a), ...e under- ...use last.

...ditions contrib- ...dth but not ...o ...e terminal ...ction given

...ile

...e: Chapter 137, ...of 54 requires ...cians to print or ...t cause or ...s death on ...ceificates, and ...ter 8, Acts of ...requires Physi- ...to rint or type ...un r signature.

...al Directors ...e to only ...AC Ink.

...P 5 - 1962

...-61-0213

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

RI R-301A

INSTRUCTIONS FOR CA CERTIFICATE

I giving SE OF DEATH

Do not enter or than one ... for each a (b) and (c)

...es not mean ... of dying, as heart failure, etc. It means ... or compli- which caused

...ons, if any, have rise to ... cause (a), ... the under- ... cause last

...ons contrib- to oth but not ... the technol ...dition given

...te Chapter 137, ...1954, requires ...ions to print or ...e cause or ...of death on ...certificates, and ...48, Acts of ... Physi- ... print or type ...ider signature.

...ial Exam- ...rwaived ...diction

...AR 5 - 1962

...6-928145

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

38

OUT - OF - STATE

To be filed for burial permit with Board of Health or its Agent.

Registered No. 013690

PLACE OF DEATH

1 Suffolk (County)

Boston (City or Town)

The Children's Hospital Medical Ctr. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Scott Clarke (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence, No. 236 Shore Drive St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence ..... years ..... months ..... days.

15Hrs. 40 Min.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb. 6, 1962 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1962 to Feb. 6, 1962

I last saw him alive on Feb. 6, 1962, death is said to have occurred on the date stated above, at 4:10P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Marasmus — INTERVAL BETWEEN ONSET AND DEATH

Due To (b) Mal-nutritional

Due To (c) Mal-nutritional Diarrhea

OTHER SIGNIFICANT CONDITIONS Diarrhea

Was autopsy performed? Yes

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? ..... If so, specify .....

(Signed) John W. Mitchell, M. D.
John W. Mitchell
(PRINT OR TYPE SIGNATURE)

(Address) 300 Longwood Ave. Date Feb. 7, 1962

6 Agudath Israel, West Roxbury
Place of Burial or Cremation (City or Town)

DATE OF BURIAL February 8, 1962

7 NAME OF FUNERAL DIRECTOR Benjamin Birnbach

ADDRESS 10 Washington St. Dorch.

Received and filed FEB 12 1962 19..
Charles M. Black D.
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Single

10a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE ..... Years 2 Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: .....
(Kind of work done during most of working life)

14 Industry or Business: .....

15 Social Security No. .....

16 BIRTHPLACE (City) (State or country) Boston, Mass.

PARENTS

17 NAME OF FATHER Jean Robin Clarke

18 BIRTHPLACE OF FATHER (City) (State or country) Winthrop

19 MAIDEN NAME OF MOTHER Judith Carol Goldov

20 BIRTHPLACE OF MOTHER (City) (State or country) Boston

21 Informant Jean Clarke
(Address) 236 Shore Drive, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

D. J. McKenzie
(Signature of Agent of Board of Health or other)

5768 — 2-8-62
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

RECEIVED

OFFICE OF TOWN CLERK WINTHROP, MASS.

APR 5 1962 PM

R-305

WRITE PLAINLY WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-3-61-930213

39

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(City or town making return)

Registered No. 01444

PLACE OF DEATH

1 Suffolk (County)

Boston (City or Town)

No. Boston City Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Catherine Christopher (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 46 Main St. St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 7, 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Multiple fractures. Auto accident. Driver of car in collision with abutment. Boston 2/5/62.

5 Accident, suicide, or homicide (specify) .....

Date and hour of injury .....19.....

If accidental, was injury causally related to the death? .....

Where did Injury occur? .....
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? .....
(Specify type of place)

Manner of Injury .....
(How did injury occur?)

Nature of Injury .....

While at work? .....Was autopsy performed? .....

6 Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) Richard Ford M. D.

(Address) .....Date 2/8/62 19

7 St. Michael Jamaica Plain
Place of Burial or Cremation. (City or Town)

DATE OF BURIAL Feb. 12, 1962 19

8 NAME OF FUNERAL DIRECTOR Alexander F. Thomas

ADDRESS 22 Oak St., Hyde Park

Received and filed APR 5 - 1962 19

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 CITIZEN OF U.S.	12 SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐
F	W	YES ☐ NO ☐	W

12a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Augustus Christopher
(Husband's name in full)

13 DATE OF BIRTH

14 AGE 40 Years.....Months.....Days — If under 24 hours .....Hours .....Minutes

15 Usual Occupation: Bookkeeper
(Kind of work done during most of working life)

16 Industry or Business: .....

17 Social Security No. .....

18 BIRTHPLACE (City) (State or country) Boston

PARENTS

19 NAME OF FATHER Angelo Arno

20 BIRTHPLACE OF FATHER (City) (State or country) Italy

21 MAIDEN NAME OF MOTHER Josephine Gangemi

22 BIRTHPLACE OF MOTHER (City) (State or country) Italy

23 Informant Anthony Arno
(Address) 36 Greenwood Ave., Hyde Park

A TRUE COPY
ATTEST: Charles H. Mack
(Registrar of City or Town where death occurred)

DATE FILED Feb. 13, 1962 19

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

RECEIVED

TOWN CLERK

APR 6 5

WINTHROP, MASS.

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

APR – 5 1962 PM

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 40

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. Mayflower Nursing Home, 39 Grovers Ave., St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Catherine Page (Davis)
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 22 Loring Road St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months 4 days. In place of residence 10 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 2 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from August, 1958, to March 2, 1962

I last saw her alive on March 2, 1962, death is said to have occurred on the date stated above, at 6:45 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Cerebral Arteriosclerosis. 2yrs.

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS Broncho pneumonia 1day

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signed) Charles Lieberman M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) Winthrop, Mass. Date 3/3/1962

6 Winthrop Cemetery, Winthrop
Place of Burial or Cremation (City or Town)
DATE OF BURIAL March 5th 1962

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.
ADDRESS 917 Bennington St., E.Boston

Received and filed MAR 5 1962 19....
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 CITIZEN OF U.S.	11
Female	White	YES ☒ NO ☐	SINGLE ☐ MARRIED ☐ WIDOWED ☒ DIVORCED ☐ UNKNOWN ☐

11a If married, widowed, or divorced
HUSBAND of ....
(Give maiden name of wife in full)
(or) WIFE of Harvey W. Page
(Husband's name in full)

12 DATE OF BIRTH Oct.6,1878

13 AGE 83 Years 4 Months 24 Days — If under 24 hours ....Hours....Minutes

14 Usual Occupation: R.N. Nurse
(Kind of work done during most of working life)

15 Industry or Business: Nursing

16 Social Security No. ....

17 BIRTHPLACE (City) East Boston
(State or country) Mass.

PARENTS

18 NAME OF FATHER Joseph Davis

19 BIRTHPLACE OF FATHER (City) ....
(State or country) Ireland

20 MAIDEN NAME OF MOTHER Mary Baker

21 BIRTHPLACE OF MOTHER (City) ....
(State or country) Ireland

22 Informant Richard B. Page-son
(Address) 22 Loring Rd., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit) 3/3/62

A TRUE COPY ATTEST:

I R-301

TICTIONS OR L CERTIFICATE

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Chapter 137, of 54 requires cians to print or the cause or death on certificates, and 8, Acts of requires Physi- to print or type signature.

61-0213

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R-301A

STRUCTIONS
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AL CERTIFICATE

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-60-33145

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 41

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Joseph (First Name) J. (Middle Name) Mahoney (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 237 Woodside Ave (Usual place of abode) St. Winthrop (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 9 days. In place of residence 24 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March (Month) 3 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 11/12, 1961, to March 3, 1962
I last saw h. alive on March 3, 1962, death is said to have occurred on the date stated above, at 10:05 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH 2 wks
Due To (b) Carcinoma of
Due To (c) lesser lung (Epidermoid) — 14 mos
OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No
What test confirmed diagnosis? Surgery & Path report

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) Joseph Gregorie M. D.
(PRINT OR TYPE SIGNATURE) Joseph Gregorie
(Address) 194 Washington Ave Date 3/3 1962

6 Place of Burial or Cremation Holy Cross Cemetery (City or Town) Malden Mass
DATE OF BURIAL March 6, 1962

7 NAME OF FUNERAL DIRECTOR Madeline G. Casey
ADDRESS 295 Washington Ave Chelsea

Received and filed MAR 5 1962 19.....
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male
9 COLOR White
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Married

10a If married, widowed, or divorced
HUSBAND of Elizabeth F. Holland
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 69 Years 3 Months 20 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Vice President Retired
(Kind of work done during most of working life)

14 Industry or Business: McKinnon & McKenzie

15 Social Security No. 010-09-3173

16 BIRTHPLACE (City) Chelsea
(State or country) Massachusetts

PARENTS

17 NAME OF FATHER Daniel Mahoney

18 BIRTHPLACE OF FATHER (City) Chelsea
(State or country) Massachusetts

19 MAIDEN NAME OF MOTHER Mary Murphy

20 BIRTHPLACE OF MOTHER (City) .....
(State or country) Ireland

21 Informant Elizabeth F. Mahoney
(Address) 237 Woodside Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Ralph C. Swanson
(Signature of Agent of Board of Health or other)
Health Officer 3/5/62
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-302

WRITE PLAINLY—WITH UNFADING INK—THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-9-59-926111

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Registered No. 42

Danvers (City or Town making this return)

PLACE OF DEATH

1 Essex (County)

Danvers (City or Town)

No. Danvers State Hospital, Hathorne St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mathias E. Munsen
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 255 Pleasant St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years 1 months 12 days. In place of residence ....years ....months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March (Month) 3, (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from January 19 1962 to March 3, 1962

I last saw him alive on March 3, 1962, death is said to have occurred on the date stated above, at 6:00 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Arteriosclerotic heart disease — years

Due (b) Generalized Arteriosclerosis — years

Due To (c) — days

OTHER SIGNIFICANT CONDITIONS Virus Infection

Was autopsy performed? no
What test confirmed diagnosis? Clinical & Laboratory

5 Was disease or injury in any way related to occupation of deceased? ....
If so, specify ....

(Signed) Andrew Nichols III, M. D.
Andrew Nichols III
(Address) Hathorne, Mass. Date 3/3/ 1962

6 Place of Burial or Cremation Winthrop Cemetery, Winthrop, Mass. (City or Town)
DATE OF BURIAL March 6, 1962

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh
ADDRESS Winthrop, Mass.

Received and filed MAR 28 1962 19....
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male | 9 COLOR white | 10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word) married

10a If married, widowed, or divorced
HUSBAND of Thelma Kendall
(Give maiden name of wife in full)

(or) WIFE of ....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 77 Years 5 Months 21 Days | If under 24 hours ....Hours ....Minutes

13 Usual Occupation: Retired Bartender
(Kind of work done during most of working life)

14 Industry or Business: ....

15 Social Security No. 265-01-6950

16 BIRTHPLACE (City) Unknown
(State or country) Norway

PARENTS

17 NAME OF FATHER Lars Munsen

18 BIRTHPLACE OF FATHER (City) Unknown
(State or country) Norway

19 MAIDEN NAME OF MOTHER Unknown

20 BIRTHPLACE OF MOTHER (City) Unknown
(State or country) Unknown

21 Informant Georgie T. Brimigion
(Address) Hathorne, Mass.

A TRUE COPY
ATTEST: Daniel J. Toomey
(Registrar of City or Town where death occurred)

DATE FILED March 8, 1962

T J.B.V.

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

M R-301

S'UCTIONS
FOR
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3-6 0213

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 43

1 PLACE OF DEATH
SUFFOLK (County)
WINTHROP (City or Town) Number 147
No. BAY VIEW REST HOME 140 WASH AVE St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME MARY C HONAN (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Residence. No. 252 Winthrop SHORE DRIVE St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months 7 days. In place of residence 45 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 10 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec, 1961, to March 10, 1962
I last saw he alive on March 6, 1962, death is said to have occurred on the date stated above, at 7:04 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Myocardial Heart Disease — yrs
Due To (b) Arteriosclerosis-Gen — yrs
Due To (c)
OTHER SIGNIFICANT CONDITIONS Congestive failure — months

Was autopsy performed?
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Joseph Gregorie, M. D.
(Print or Type Name) JOSEPH GREGORIE
(Address) 194 Washington Date 3/10 1962

6 HOLYWOOD BROOKLINE, Boston
Place of Burial or Cremation (City or Town)
DATE OF BURIAL MARCH 12 1962

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY
ADDRESS WINTHROP

Received and filed MAR 12 1962 19.....
(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: FEMALE
9 COLOR: WHITE
10 CITIZEN OF U.S.: YES ☒ NO ☐
11 SINGLE ☐ MARRIED ☒ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐

11a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 DATE OF BIRTH

13 AGE 77 Years.....Months.....Days — If under 24 hours .....Hours.....Minutes

14 Usual Occupation: U.S. INTERNAL REVENUE
(Kind of work done during most of working life)

15 Industry or Business: CLERK

16 Social Security No. NONE

17 BIRTHPLACE (City) FALL RIVER
(State or country) MASS.

PARENTS

18 NAME OF FATHER JOHN J HONAN.
19 BIRTHPLACE OF FATHER (City) WAREHAM.
(State or country) MASS.
20 MAIDEN NAME OF MOTHER CHRISTNE MURPHY
21 BIRTHPLACE OF MOTHER (City) PROVIDENCE
(State or country) R. I.

22 Informant BEREVIEVE McALEENAN
(Address) 252 SHORE DRIVE WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit) March 11, 1962

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

M R-302

MARGIN RESERVED FOR BINDING — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-8-56-918227

X

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Lynn (City or Town making this return)

Registered No. 44

1 PLACE OF DEATH
Essex (County)
Lynn (City or Town)
No. Lynnview Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Elizabeth Snook (McQuillan)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 37 Temple Ave. St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..years 4 months ..days. In place of residence ..years ..months ..days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 13, 1962 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 24, 1961, to Mar. 13/62, 19.. I last saw her alive on Mar. 13/62, 19.., death is said to have occurred on the date stated above, at 2:45 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Metastasis, generalized	5 mos.
Due To (b) Carcinoma of Sigmoid	1 yr.
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Hypothyroidism	yrs.

Was autopsy performed? no
What test confirmed diagnosis? colostomy

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) Clarence London, M. D.
(Address) Lynnview Hosp. Date 3/13/62

6 Fishkill Cem. Fishkill, N.Y.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL March 17. 62 19..

7 NAME OF FUNERAL DIRECTOR Howard S. Reynolds
ADDRESS Winthrop, Mass.

Received and filed MAR 30 1962 19..
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX fe | 9 COLOR wh | 10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) wid.

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Aaron
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 79 Years 1 Months 22 Days | If under 24 hours ..Hours ..Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No. none

16 BIRTHPLACE (City) East Boston
(State or country) Mass.

PARENTS

17 NAME OF FATHER John J. McQuillan

18 BIRTHPLACE OF FATHER (City) E.Boston
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Virginia A. Strong

20 BIRTHPLACE OF MOTHER (City)
(State or country) c/n/b/1

21 Informant John Snyder
(Address) 37 Temple Ave., Winthrop

A TRUE COPY
ATTEST: Albert L. Stymes
(Registrar of City or Town where death occurred)

DATE FILED Mar. 20/62 19..

Removed here!

V.B.

R-305

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON. THIS IS A PERMANENT RECORD.

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-4-59-925100

The Commonwealth of Massachusetts
JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Lynn
(City or town making return)

Registered No. 45

X

1 PLACE OF DEATH: Essex County; Lynn (City or Town)

No. DOA Lynn Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Laurence J. Edwards (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) WW II

(a) Residence. No. 19 Johnson Avenue St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months 1 days. In place of residence 15 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 17, 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury, this involved, specify)

Sudden death, presumably coronary occlusion.

5 Accident, suicide, or homicide (specify) ....

Date and hour of injury ....19....

If accidental, was injury causally related to the death? ....

Where did Injury occur? ....
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ....
(Specify type of place)

Manner of Injury ....
(How did injury occur?)

Nature of Injury ....

While at work? .... Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? ....
If so, specify ....

(Signed) Edmund A. Jannino M. D.

(Address) 181 N. Common St. Lynn Date 3/17/62 19....

7 Place of Burial, or Cremation. Holy Cross Cem. Malden, Mass. (City or Town)

DATE OF BURIAL March 20, 1962 19....

8 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.

ADDRESS 917 Bennington St., E. Boston

Received and filed MAR 30 1962 19....
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX m

10 COLOR wh

11 SINGLE MARRIED WIDOWED or DIVORCED (write the word) X

11a If married, widowed, or divorced HUSBAND of Roberta K. O'Donnell
(Give maiden name of wife in full)

(or) WIFE of ....
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 48 Years 10 Months 17 Days | If under 24 hours ....Hours....Minutes

14 Usual Occupation: Manager
(Kind of work done during most of working life)

15 Industry or Business: First National Stores

16 Social Security No. 024-03-0404

17 BIRTHPLACE (City) E. Boston (State or country) Mass.

PARENTS

18 NAME OF FATHER Peter W. Edwards

19 BIRTHPLACE OF FATHER (City) Newfoundland (State or country)

20 MAIDEN NAME OF MOTHER Margaret M. Drew

21 BIRTHPLACE OF MOTHER (City) E. Boston (State or country) Mass.

22 Informant Mrs. Roberta K. Edwards (Address) 19 Johnson Ave., Winthrop, Mass

A TRUE COPY: ATTEST: Robert L. Lehmann
(Registrar of City or Town where death occurred)

DATE FILED Mar 20/62 19....

V.B.V

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

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R-301A

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I-6-3 25686

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 46

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. ~~142 Pleasant Street~~ Winthrop Health Care Center St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Fannie (Holland) Scott (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 154 Bowdon Street St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 1 years months days. In place of residence 30 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March (Month) 17, (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb. 18, 1956, to March 17, 1962

I last saw her alive on March 15, 1962, death is said to have occurred on the date stated above, at 1:30 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Arteriosclerotic & hypertensive heart disease	5 yrs.
Due To (b) Generalized arteriosclerosis	8 yrs.
Due To (c) Cerebral arteriosclerosis	2 yrs.
OTHER SIGNIFICANT CONDITIONS Diabetes mellitus	2 yrs.

Was autopsy performed? no
What test confirmed diagnosis? Clinical & laboratory

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) M. Traunstein Jr. M. D.
M. Traunstein, Jr., M. D.
(PRINT OR TYPE SIGNATURE)
(Address) 73 Bartlett Rd., Date March 19, 62

6 Place of Burial or Cremation Garden Cemetery (City or Town) Chelsea, Mass.
DATE OF BURIAL March 20 1962

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds
ADDRESS Winthrop, Mass

Received and filed March 20, 1962
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female
9 COLOR White
10 SINGLE, MARRIED, WIDOWED, or DIVORCED (write the word) Married

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Harry A Scott
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 83 Years 3 Months 1 Days
If under 24 hours Hours Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own home

15 Social Security No. None

16 BIRTHPLACE (City) (State or country) England

PARENTS

17 NAME OF FATHER John Holland

18 BIRTHPLACE OF FATHER (City) (State or country) England

19 MAIDEN NAME OF MOTHER Elizabeth Cabel

20 BIRTHPLACE OF MOTHER (City) (State or country) England

21 Informant Harry A Scott
(Address) 154 Bowdon St. Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sullivan
(Signature of Agent of Board of Health or other)
Health Officer 3/20/62
(Official Designation) (Date of Issue of Permit)

V.B.V

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R-301

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-61-9313

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 47

PLACE OF DEATH

1 Suffolk (County) Boston 4-6-62
Winthrop (City or Town)
No. Mount's Convalescent Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME John A. Carroll (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence, No. 15 Moore St. East Boston
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 10 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March (Month) 18 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from March 18, 1962, to....., 19.....
I last saw him alive on March 18, 1962, death is said to have occurred on the date stated above, at 11:45 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Cardiac Decompensation
Due To (b) Chronic Myocarditis
Due To (c) carcinomatosis primary
OTHER SIGNIFICANT CONDITIONS rt. lower lung

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? .....
What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) A. Nathan Caplan, M. D.
A. NATHAN CAPLAN
(Print or Type Name)
(Address) 186 Princeton St. E. Bos. Date Mar. 19 1962

6 Holy Cross Malden
Place of Burial or Cremation (City or Town)
DATE OF BURIAL March 21 1962

7 NAME OF FUNERAL DIRECTOR Frederick J. Magrath
ADDRESS East Boston

Received and filed MAR 20 1962 19.....
(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 CITIZEN OF U.S.: YES ☑ NO ☐
11 SINGLE ☐ MARRIED ☑ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐

11a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 DATE OF BIRTH

13 AGE 77 Years.....Months.....Days
If under 24 hours .....Hours.....Minutes

14 Usual Occupation: Laborer
(Kind of work done during most of working life)

15 Industry or Business: Retired

16 Social Security No. CNDI

17 BIRTHPLACE (City) Charlestown
(State or country) Mass.

PARENTS

18 NAME OF FATHER James Carroll

19 BIRTHPLACE OF FATHER (City) .....
(State or country) Ireland

20 MAIDEN NAME OF MOTHER Mary Griffin

21 BIRTHPLACE OF MOTHER (City) .....
(State or country) New Brunswick

22 Informant James P. Carroll
(Address) 15 Moore St. E. Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit-permit was issued:
Ralph E. Sullivan
(Signature of Agent of Board of Health or other)
Health Officer 3/20/62
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation bad been given up or changed, or if tbe deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R-301A

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MED. EXAM CALLED → DECLINED JURISDICTION

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 48

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME MARY BELLE SMITH (Mac Quarrie) (Was deceased a U. S. War Veteran, if so specify WAR) NO.
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. 9 Marshall Street St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death years 1 months 21 days. In place of residence 34 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAR 18 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from JAN, 1953, to MAR 18, 1962
I last saw her alive on MAR 15 1962, death is said to have occurred on the date stated above, at 12:45 P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	ACUTE CORONARY OCC	2½ hrs
Due To (b)	ARTERIO-SCLEROTIC & HYPERTENSIVE HEART DISEASE	9 YRS
Due To (c)	GENERAL ARTERIOSCLEROSIS.	9 YRS.
OTHER SIGNIFICANT CONDITIONS	DIABETES MELLITUS.	9 YRS
	CARINOMA OF CERVIX METASTASIS TO RT. HIP & FIBULA	10 YRS. 16 DAYS

Was autopsy performed? NO
What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signed) Myron N. King, M. D.
MYRON N. KING M.D
(PRINT OR TYPE SIGNATURE)
(Address) 122 BLEASANT ST WINTHROP Date 3/18 1962

6 Winthrop Cemetery Winrhrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 21, 1962 19

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop,

Received and filed 19
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female
9 COLOR: white
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word): married

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Walter Smith
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 56 Years 4 Months 3 Days — If under 24 hours Hours Minutes

13 Usual Occupation: housework (wife)
(Kind of work done during most of working life)

14 Industry or Business: own home

15 Social Security No. none

16 BIRTHPLACE (City) Roxbury
(State or country) Massachusetts

PARENTS

17 NAME OF FATHER John E. MacQuarrie

18 BIRTHPLACE OF FATHER (City)
(State or country) Nova Scotia

19 MAIDEN NAME OF MOTHER Dora MacInnis

20 BIRTHPLACE OF MOTHER (City)
(State or country) Nova Scotia

21 Informant Walter Smith
(Address) 9 Marshall St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Mass.
(Signature of Agent of Board of Health or other) Ralph E. Jerauld
Health Officer 3/20/62
(Official Designation) (Date of Issue of Permit)

V.A.

AR 20 1962

60-97 45

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301A

INSTRUCTIONS FOR CERTIFICAL CERTIFICATE

In giving CAUSE OF DEATH

Do not enter more than one cause for each (a), (b) and (c)

"Cause" does not mean mode of dying, as heart failure, asphyxia, etc. It means disease, or complication which caused death.

Conditions, if any, which gave rise to the cause (a), stating the underlying cause last.

Other conditions contributing to death but not related to the terminal disease condition given in (a).

Note:- Chapter 137, Acts of 1954, requires Physicians to print or type the cause or causes of death on death certificates, and Chapter 48, Acts of 1959, requires Physicians to print or type name under signature.

Acts 1971, C.

MAR 27 1962

-6-60-928145

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 50

1 PLACE OF DEATH: Suffolk (County) — Winthrop (City or Town)

No. 26 Lincoln Street St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Anna Burton Day (Morgan) (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO.

(a) Residence. No. 26 Lincoln Street St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 7 years ... months ... days. In place of residence 7 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March (Month) 21 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from SEPT 26, 1957, to MAR 21, 1962

I last saw h[illegible] alive on MAR 21, 1962, death is said to have occurred on the date stated above, at 4:46 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) ARTERIO-SCLEROTIC HEART DIS & SENILE PSYCHOSIS — INTERVAL BETWEEN ONSET AND DEATH: 1 YR.

Due To (b) GENERAL ARTERIOSCLERSIS — 5 YRS

Due To (c)

OTHER SIGNIFICANT CONDITIONS: DECUBITUS ULCERS — 4 MO.

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Myron N. King, M. D.
MYRON N. KING M.D.
(PRINT OR TYPE SIGNATURE)

(Address) 222 PLEASANT ST WINTHROP Date 3/22 1962

6 Winthrop Cemetery Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 23 1962

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed ... 19...
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female

9 COLOR: white

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Widowed

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of William Arnold Day
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 94 Years 5 Months 27 Days — If under 24 hours ... Hours ... Minutes

13 Usual Occupation: housework
(Kind of work done during most of working life)

14 Industry or Business: own home

15 Social Security No. none

16 BIRTHPLACE (City) (State or country) Wales

PARENTS

17 NAME OF FATHER Richard Morgan

18 BIRTHPLACE OF FATHER (City) (State or country) Wales

19 MAIDEN NAME OF MOTHER Sarah Burton

20 BIRTHPLACE OF MOTHER (City) (State or country) Wales

21 Informant Mrs. Robert H. Collignon
(Address) 26 Lincoln St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Walter C. Hermans
(Signature of Agent of Board of Health or other)

Health Officer (Official Designation) 3/27/62 (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE..... RECEIVED .....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

CM R-301A

STRUCTIONS FOR
DAL CERTIFICATE

In giving
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f), (b) and (c)

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Note:- Chapter 137,
of 1954, requires
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16-60-928145

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 51

X

1 PLACE OF DEATH
Winthrop (County)
Suffolk (City or Town)

No. Mayflower Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Edith (Hewson) Webster
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO.

(a) Residence, No. 140 Circuit Road St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months 15 days. In place of residence 54 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 24 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....
I last saw h....alive on ....., 19...., death is said to have occurred on the date stated above, at ....m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) A

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed?
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) ....., M. D.
(PRINT OR TYPE SIGNATURE)
(Address) ....Date....19....

6 Woodlawn Cemetery, Everett, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL March 27, 1962 19....

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh
ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed MAR 28 1962 19....
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female
9 COLOR: white
10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): widowed

10a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of John Archibald Webster
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 77 Years 3 Months 3 Days — If under 24 hours ....Hours....Minutes

13 Usual Occupation: retired owner
(Kind of work done during most of working life)

14 Industry or Business: restaurant

15 Social Security No. 051-12-7503

16 BIRTHPLACE (City) Liverpool
(State or country) England

PARENTS

17 NAME OF FATHER Michael J. Hewson

18 BIRTHPLACE OF FATHER (City) .....
(State or country) England

19 MAIDEN NAME OF MOTHER Sophia Goodwin

20 BIRTHPLACE OF MOTHER (City) .....
(State or country) England

21 Informant Walter H. Webster
(Address) 140 Circuit Rd. Winthrop

I HEREBY CERTIFY, that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Ralph E. Sereanian
(Signature of Agent of Board of Health or other)
Health Officer
(Official Designation)
3/27/62
(Date of Issue of Permit)

X

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

DM R-301A

STRUCTIONS FOR DIAL CERTIFICATE

n giving E OF DEATH

not enter re than one se for each (), (b) and (c)

h does not mean ode of dying, s heart failure, ert, etc. It means ease, or compli- n which caused h

nditions, if any, h gave rise to c cause (a), g the under- n cause last.

Conditions contrib- to death but not e to the terminal condition given a

Note:- Chapter 137, of 1954, requires hicians to print or the cause or s of death on s certificates, and ter 48, Acts of 5 requires Physi- to print or type under signature.

M-60-928145

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 52

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

Melrose 4-6-1962

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Samuel A. Waugh
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 84 Orchard Lane St. Welrose
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years 1 months 14 days. In place of residence ....years ....months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March (Month) 25 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from March 8, 1962, to March 25, 1962.
I last saw h. alive on March 25, 1962, death is said to have occurred on the date stated above, at 1 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Hepatic Failure

Due To (b) Carcinoma of the Pancreas

Due To (c)

OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH: 2 months

Was autopsy performed?
What test confirmed diagnosis? Surgery Biopsy

5 Was disease or injury in any way related to occupation of deceased? — no —
If so, specify

(Signed) S. A. De Luca, M. D.
S. A. DE LUCA M.D.
(PRINT OR TYPE SIGNATURE)
(Address) 550 Park Ave Date March 26 1962

6 Puritan Lawn Peabody
Place of Burial or Cremation (City or Town)
DATE OF BURIAL March 28, 1962 19

7 NAME OF FUNERAL DIRECTOR Leslie W. Pike
ADDRESS 305 Beach St Revere

Received and filed MAR 28 1962 19
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male
9 COLOR White
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Married

10a If married, widowed, or divorced
HUSBAND of Marjorie Rogers
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 60 Years 6 Months 24 Days
If under 24 hours ....Hours ....Minutes

13 Usual Occupation: Auto Dealer
(Kind of work done during most of working life)

14 Industry or Business: Automobile

15 Social Security No.

16 BIRTHPLACE (City) Revere
(State or country) Mass

PARENTS

17 NAME OF FATHER Samuel A. Waugh

18 BIRTHPLACE OF FATHER (City)
(State or country) Ireland

19 MAIDEN NAME OF MOTHER Susan MacWilliams

20 BIRTHPLACE OF MOTHER (City) Randolph
(State or country) Mass

21 Informant Marjorie Waugh
(Address) 84 Orchard Lane Welrose

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Williams
(Signature of Agent of Board of Health or other)
Health Officer 3/28/62
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

DRM R-301A

INSTRUCTIONS FOR ICAL CERTIFICATE

In giving ISE OF DEATH

do not enter nore than one ause for each c(a), (b) and (c)

is does not mean mode of dying, as heart failure, nia, etc. It means disease, or compli- ns which caused t.

nditions, if any, ich gave rise to ve cause (a), ting the under- ng cause last.

Conditions contrib- to death but not ed to the terminal se condition given t).

Note:- Chapter 137, of 1954, requires icians to print or the cause or s of death on certificates, and ter 48, Acts of requires Physi- to print or type under signature.

M.C.

MAR 29 1962

OM-11-59-926662

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 53

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Charles Wilox Hunter (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) NO.

(a) Residence. No. 84 Lincoln St St. Winthrop (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months.... 55 Min. In place of residence 30 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March (Month) 26 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from March 26, 1962, to March 26, 1962, I last saw him alive on March 26, 1962, death is said to have occurred on the date stated above, at 1:45 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH 1 hr, 15 min

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) Joseph Zambella, M. D.
Joseph Zambella, MD
(PRINT OR TYPE SIGNATURE)
(Address) 327 Sumner St. Boston 7-26-62

6 Place of Burial or Cremation Winthrop Cemetery, Winthrop, Mass. (City or Town)
DATE OF BURIAL March 30, 1962 19

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh
ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed 19
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male
9 COLOR white
10 SINGLE, MARRIED, WIDOWED, or DIVORCED (write the word) married

10a If married, widowed, or divorced, HUSBAND of Barbara Cameron (Give maiden name of wife in full)
(or) WIDOW of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 62 Years 4 Months 20 Days — If under 24 hours ....Hours....Minutes

13 Usual Occupation: Photo engraver (Kind of work done during most of working life)

14 Industry or Business: Boston Newspapers

15 Social Security No. 011-01-2409

16 BIRTHPLACE (City) Gardner (State or country) Maine

PARENTS

17 NAME OF FATHER Charles Wilox Hunter

18 BIRTHPLACE OF FATHER (City) Boston (State or country) Massachusetts

19 MAIDEN NAME OF MOTHER Ida May DeMerrit

20 BIRTHPLACE OF MOTHER (City) Boston (State or country) Massachusetts

21 Informant Mrs. Charles W. Hunter
(Address) 84 Lincoln St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Walter E. Sercanny
(Signature of Agent of Board of Health or other)
Health Officer 3/29/62
(Official Designation) (Date of Issue of Permit)

V.E.

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE..... .....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from diseases unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

M R-301A

ISTRUCTIONS FOR
AL CERTIFICATE

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UE OF DEATH

not enter
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se for each
), (b) and (c)

h does not meon ode of dying, s heart failure, ea, etc. It means ease, or compli- which coused

ditions, if ony, hh gave rise to e couse (a), ing the under- ie couse last.

nditions contrib- o death but not to the terminol condition given

:- Chapter 137, f 1954, requires ians to print or e the cause or of death on certificates, and er 48, Acts of requires Physi- to print or type under signature.

MAR 29 1962

M-6-59-925686

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 54

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

2 FULL NAME Alexance xxxxxxx E. Murad (Moore)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 7 Ingleside Ave, Winthrop St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death years. 2 months days. In place of residence 40 years. months. days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 27, 1962 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1962, to MAR 27, 1962
I last saw him alive on MAR. 27, 1962, death is said to have occurred on the date stated above, at 8:17 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) GENERALIZED CARCINOMATOSIS	1 MO.
Due To (b) CARCINOMA OF STOMACH	3 MO.
Due To (c)	
OTHER SIGNIFICANT CONDITIONS GENERAL ARTERIOSCLEROSIS	

Was autopsy performed? No
What test confirmed diagnosis? BIOPSY, CLINICAL, OPERATION

5 Was disease or injury in any way related to occupation of deceased No
If so, specify

(Signed) Myron N. King, M. D.
MYRON N. KING M.D.
(PRINT OR TYPE SIGNATURE)
(Address) 222 PLEASANT ST. Date 3/27 1962

6 Rock Ridge Cemetery Sharon, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL March 30, 1962 19

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh
ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed 19
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female
9 COLOR: white
10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): widowed

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Alexander M. Murad Moorad
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 77 Years 3 Months 9 Days | If under 24 hours Hours Minutes

13 Usual Occupation: Hospital Maid
(Kind of work done during most of working life)

14 Industry or Business: Winthrop Community Hospital

15 Social Security No. 010-07-8712-D

16 BIRTHPLACE (City) Birmingham
(State or country) England

PARENTS
17 NAME OF FATHER Henry Moore
18 BIRTHPLACE OF FATHER (City)
(State or country) England
19 MAIDEN NAME OF MOTHER Elizabeth Roath
20 BIRTHPLACE OF MOTHER (City)
(State or country) England

21 Informant (Address) Mrs. Lawrence T. Burns 5 Ingleside Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Ralph E. Sirianni
(Signature of Agent of Board of Health or other)
Health Officer 3/29/62
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

OM R-301A

ISTRUCTIONS FOR DIAL CERTIFICATE

n giving E OF DEATH

not enter re than one ase for each (), (b) and (c)

h does not mean ode of dying, heart failure, ea, etc. It means ease, or compli- n which caused h

ditions, if any, h gave rise to e cause (a), g the under- n cause last.

Conditions contrib- g to death but not e to the terminal s condition given a

Note:- Chapter 137, of 1954, requires ysicians to print or p the cause or us of death on e certificates, and hapter 48, Acts of 5 requires Physi- s to print or type ar under signature.

M-60-928145

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 55

X

1 PLACE OF DEATH

Suffolk (County)

Winthrop (City or Town)

No. 475 Shirley St. St. {(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Albert F. Beddeos (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 119 Terrace Avenue St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 40 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 28, 1962 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to....., 19.....

I last saw h.....alive on ....., 19....., death is said to have occurred on the date stated above, at 4.40 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death due to natural

Due To (b) causes presumably due to

Due To (c) acute coronary occlusion

OTHER SIGNIFICANT CONDITIONS due arteriosclerotic heart disease

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? Winthrop Board of Health

What test confirmed diagnosis? Charles Liberman M.D.

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) Charles Liberman, M. D.
CHARLES LIBERMAN, M.D.
(PRINT OR TYPE SIGNATURE)

(Address) WINTHROP Date 3/28/ 19 62

6 Winthrop Place of Burial or Cremation Winthrop (City or Town)

DATE OF BURIAL March 31, 19 62

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop Mass

Received and filed MAR 30 1962 19.....
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Divorced

10a If married, widowed, or divorced HUSBAND of Helene Ezekiel
(Give maiden name of wife in full)

(or) WIFE of .....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 53 Years.....Months.....Days | If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Gas Sta Proprietor
(Kind of work done during most of working life)

14 Industry or Business: Automobile

15 Social Security No. .....

16 BIRTHPLACE (City) Somerville
(State or country) Mass

PARENTS

17 NAME OF FATHER Earl Beddeos

18 BIRTHPLACE OF FATHER (City) Arlington
(State or country) Mass

19 MAIDEN NAME OF MOTHER Frances Brown

20 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Mass

21 Informant Helene Beddeos
(Address) 119 Terrace Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Liberman
(Signature of Agent of Board of Health or other)

Health Officer 3/30/62
(Official Designation) (Date of Issue of Permit)

T V.K. V

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

M R-301A

ISTRUCTIONS FOR DAL CERTIFICATE

In giving UE OF DEATH

not enter re than one se for each (), (b) and (c)

h does not mean ode of dying, s heart failure, e, etc. It means ease, or compli- which caused h

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M.C.

5-60-928145

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 56

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. 177 Somerset Avenue St. {(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT
{(Was deceased a U. S. War Veteran, if so specify WAR) No

2 FULL NAME Lillian J. Laidlaw
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 177 Somerset Avenue St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months....days. In place of residence 10 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAR (Month) 30 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from JAN, 1960, to MAR 30, 1962
I last saw he alive on MAR 30, 1962, death is said to have occurred on the date stated above, at 8 35 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) ACUTE CORONARY OCC	15 MIN
Due To (b) ARTERIO-SCLEROTIC HEART DIS	2 YRS.
Due To (c)	
OTHER SIGNIFICANT CONDITIONS NONE	

Was autopsy performed? No
What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Myron N. King, M. D.
222 PLEASANT ST WINTHROP
(PRINT OR TYPE SIGNATURE)
(Address) MYRON N. KING Date 3/31 1962

6 Place of Burial or Cremation: Holy Cross Malden, Mass (City or Town)
DATE OF BURIAL April 2, 1962

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
ADDRESS Winthrop, Mass

Received and filed APR 2 - 1962 19....
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED, or DIVORCED (write the word): Married

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Frederick W. Laidlaw
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 69 Years....Months....Days | If under 24 hours ....Hours....Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No.

16 BIRTHPLACE (City) Boston
(State or country) Mass

PARENTS
17 NAME OF FATHER George Johnson
18 BIRTHPLACE OF FATHER (City) St. Johns
(State or country) N. B.
19 MAIDEN NAME OF MOTHER Annie McNamara
20 BIRTHPLACE OF MOTHER (City) St. Johns
(State or country) N. B.

21 Informant Loretta Gallagher
(Address) 177 Somerset Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Ralph E. Lancaster
(Signature of Agent of Board of Health or other)
Health Officer 4/2/62
(Official Designation) (Date of Issue of Permit)

T. B. M.

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

M R-301A

TRUCTIONS FOR DIAL CERTIFICATE

n giving E OF DEATH

not enter re than one se for each (), (b) and (c)

h does not meon ode of dying, heart failure, ea, etc. It means ease, or compli- n which caused

nditions, if ony, h gave rise to e couse (a), g the under- i couse last.

Conditions contrib- to death but not te to the terminal condition given a

o:- Chapter 137, of 1954, requires sians to print or the cause or of death on certificates, and er 48, Acts of requires Physi- o print or type under signature.

M-6-59-925686

The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 57

1 PLACE OF DEATH: Suffolk (County) — Winthrop (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Grace (Ferrara) Caggiano
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Residence. No. 147 Winthrop St. Winthrop Mass, St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death years. 1 months days. In place of residence 15 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March (Month) 31 (Day) 1962. (Year)

4 I HEREBY CERTIFY, That I attended deceased from 3/22, 1962, to 3/31, 1962.
I last saw her alive on 3/31, 1962, death is said to have occurred on the date stated above, at 7:15 P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) GENERAL CARCINOMATOSIS AND PLEURAL EFFUSION	2MO
Due To (b) ADENOCARCINOMA OF UTERUS	1YR
Due To (c)	
OTHER SIGNIFICANT CONDITIONS NONE	

Was autopsy performed? YES
What test confirmed diagnosis? CLINICAL + PATHOLOGICAL

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Myron N. King, M. D.
MYRON N. KING M.D.
(PRINT OR TYPE SIGNATURE)
(Address) 22 PLEASANT ST WINTHROP Date APRIL 2 1962

6 Winthrop Cemetery, Winthrop
Place of Burial or Cremation (City or Town)
DATE OF BURIAL April 4, 1962

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh
ADDRESS 174 Winthrop St., Winthrop

Received and filed APR 3 - 1962 19
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female
9 COLOR: white
10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): married

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Ernest P. Caggiano
(Husband's name in full)

11 IF STILLBORN, enter that fact here

12 AGE 60 Years 8 Months 11 Days — If under 24 hours Hours Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: ~~at~~ home

15 Social Security No.

16 BIRTHPLACE (City) Messina
(State or country) Italy

PARENTS

17 NAME OF FATHER Frank Ferrara

18 BIRTHPLACE OF FATHER (City) Messina
(State or country) Italy

19 MAIDEN NAME OF MOTHER Maria Velardo

20 BIRTHPLACE OF MOTHER (City) Messina
(State or country) Italy

21 Informant Ernest P. Caggiano
(Address) 147 Winthrop St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph C. Ferrauiolo
(Signature of Agent of Board of Health or other)

Health Officer 4/3/62
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

INSTRUCTIONS FOR DEATH CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each (a), (b) and (c)

Death does not mean mode of dying, as heart failure, etc. It means disease, or complication which caused death.

Conditions, if any, which gave rise to the cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a)

Note:- Chapter 137, Acts of 1954 requires physicians to print or type the cause or causes of death on death certificates, and Chapter 48, Acts of 1955 requires Physicians to print or type their signature

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 58

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. 27 ~~Thornton~~ Thornton ST. Winthrop St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Margaret (First Name) M (Middle Name) Knox (Frasier) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No. 27 ~~Thornton~~ Thornton ST. St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 14 years — months — days. In place of residence 14 years — months — days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March (Month) 31 (Day) 62 (Year)

4 I HEREBY CERTIFY That I attended deceased from MAR 31, 1962, to MAR 31, 1962
I last saw he alive on MAR 31, 1962, death is said to have occurred on the date stated above, at 12 25 P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	GENERAL CARCINOMATOSIS	1 MO
Due To (b)	CARCINOMA OF BLADDER	1 YR
Due To (c)		
OTHER SIGNIFICANT CONDITIONS	None	

Was autopsy performed? No
What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Myron N. King, M. D.
MYRON N. KING MD
(Print or Type Name)
(Address) 22 OLEAN STREET WINTHROP Date 4/2 1962

6 Winthrop Place of Burial or Cremation — Winthrop (City or Town)
DATE OF BURIAL April 3, 1962

7 NAME OF FUNERAL DIRECTOR Maurice W. Kirby
ADDRESS 210 Winthrop ST. Winthrop

Received and filed APR 2 - 1962 19
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 CITIZEN OF U.S.	11
F	W	YES ☑ NO ☐	SINGLE ☐ MARRIED ☑ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐

11a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Albert C Knox
(Husband's name in full)

12 DATE OF BIRTH not Known 1/28-1878

13 AGE 64 Years — Months — Days. If under 24 hours ... Hours ... Minutes

14 Usual Occupation: Home
(Kind of work done during most of working life)

15 Industry or Business: House wife

16 Social Security No. none

17 BIRTHPLACE (City) East Boston
(State or country) Mass.

PARENTS

18 NAME OF FATHER Richard Frasier

19 BIRTHPLACE OF FATHER (City) Un Known
(State or country) Un Known

20 MAIDEN NAME OF MOTHER Margaret Green

21 BIRTHPLACE OF MOTHER (City) Un Known
(State or country)

22 Informant Albert C. Knox
(Address) 27 Thornton ST. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Ralph E. Sirsonny
(Signature of Agent of Board of Health or other)
Health Officer 4/2/62
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

HIS PAT. HAS BEEN UNDER MY DIRECTIONS CARE. - I AM COVERING FOR HIM

NOT REQUIRED IF ... V.B.V

3-61-930213

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

Lab Ave 1961
FRM R-303
of L.37
180 Bartlett Rd 1962

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 59

1 PLACE OF DEATH: SUFFOLK (County); WINTHROP (City or Town)

No. 130 GROVERS AVE. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

2 FULL NAME: GERARD (First Name) LaCentra (Middle Name) ~~LACENTRE~~ (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 130 GROVERS AVE St. WINTHROP
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months 7 days. In place of residence 40 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: MARCH (Month) 31 (Day) 1962 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

ACUTE ALCOHOLISM

5 Accident, suicide, or homicide (specify) ....

Date and hour of injury ....19....

IF ACCIDENTAL, was injury causally related to the death? ....

Where did Injury occur? .... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? .... (Specify type of place)

Manner of Injury .... (How did injury occur?)

Nature of Injury ....

While at work? .... Was autopsy performed NO

6 Was disease or injury in any way related to occupation of deceased? ....

If so, specify ....

(Signed) Leonard Atkins, M. D.

LEONARD ATKINS M.D. (Print or Type Name)

(Address) 25 SHATTUCK ST. Date APRIL 1 19 62

7 Winthrop Winthrop
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL April 3 19 62

8 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop Mass

Received and filed APR 2 - 1962 19....

A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 CITIZEN OF U.S.	12 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN
MALE	WHITE	YES ☒ NO ☐	☐ ☐ ☒ ☐ ☐

12a If married, widowed, or divorced
HUSBAND of Marion Horlett (Give maiden name of wife in full)
(or) WIFE of .... (Husband's name in full)

13 DATE OF BIRTH Apr 11 1882

14 AGE 79 Years 11 Months 22 Days. If under 24 hours ....Hours ....Minutes

15 Usual Occupation: Broker (Kind of work done during most of working life)

16 Industry or Business: Coffee

17 Social Security No. 021-26-5387

18 BIRTHPLACE (City) .... (State or country) Italy

PARENTS

19 NAME OF FATHER Anthony LaCentra

20 BIRTHPLACE OF FATHER (City) .... (State or country) Italy

21 MAIDEN NAME OF MOTHER Erminia Brienza

22 BIRTHPLACE OF MOTHER (City) .... (State or country) Italy

23 Informant Ruth Mossman
(Address) 95 Johnson Ave. Winthrop, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph C. Sweeney
(Signature of Agent of Board of Health or other)

Health Officer 4/2/62
(Official Designation) (Date of Issue of Permit)

NOT REQUIRED

MEDICAL

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-3-61-930213

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

OM R-301A

INSTRUCTIONS FOR DEATH CERTIFICATE

In giving TYPE OF DEATH

Do not enter more than one cause for each (a), (b) and (c)

Death does not mean mode of dying, as heart failure, etc., etc. It means disease, or complication which caused death

Conditions, if any, which gave rise to the cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in a

Note:- Chapter 137, Acts of 1954, requires physicians to print or type the cause or causes of death on death certificates, and Chapter 48, Acts of 1955 requires Physicians to print or type their under signature.

M.C.

M-60-928145

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 60

1 PLACE OF DEATH: Suffolk (County) — Winthrop (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Elsa R. Shea (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 53 Ingleside Avenue St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death years 1 months 25 days. In place of residence 40 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 31, 1962 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept. 8, 1961, to Mar. 31, 1962

I last saw her alive on March 31, 1962, death is said to have occurred on the date stated above, at 3:45 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Carcinoma of left lung with massive pleural effusion — INTERVAL BETWEEN ONSET AND DEATH: 7 mos.

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? clinical & laboratory

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) M. Traunstein, Jr. M. D
M. Traunstein, Jr., M.D.
(PRINT OR TYPE SIGNATURE)
(Address) 73 Bartlett Rd. Date 3-31 1962

6 Winthrop Place of Burial or Cremation — Winthrop (City or Town)

DATE OF BURIAL April 3 1962

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop Mass

Received and filed APR 2 - 1962 (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Widowed

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of John P. Shea
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 68 Years Months Days — If under 24 hours Hours Minutes

13 Usual Occupation: Practical Nurse
(Kind of work done during most of working life)

14 Industry or Business: Home Nursing

15 Social Security No.

16 BIRTHPLACE (City) Waterbury
(State or country) Conn

PARENTS

17 NAME OF FATHER Hermon Gartz

18 BIRTHPLACE OF FATHER (City)
(State or country) Austria

19 MAIDEN NAME OF MOTHER Mary Gramelspacka

20 BIRTHPLACE OF MOTHER (City)
(State or country) Austria

21 Informant Elsa Verdy
(Address) 53 Ingleside Ave Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Adelle C. Hekeanyo
(Signature of Agent of Board of Health or other)

Health Officer 4/2/62
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

HI R-301A

INSTRUCTIONS FOR CIAL CERTIFICATE

giving S OF DEATH

d not enter e than one e for each (b) and (c)

does not mean de of dying, heart failure, etc. It means ase, or compli- which caused

tions, if any, gave rise to cause (a), the under- cause last.

ditions contrib- death but not to the terminal condition given

66.

e: Chapter 137, of 1954, requires cians to print or the cause or s of death on certificates, and ter 48, Acts of requires Physi- to print or type under signature.

AY 8 - 1962

K

OUT OF - TOWN

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

61

To be filed for burial permit with Board of Health or its Agent.

Registered No. 02116

PLACE OF DEATH

1 Suffolk (County)

BRIGHTON (City or Town)

No. ST. Elizabeth's Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Baby Boy Colpak (First Name) (Middle Name) (Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 150 Locust St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months...8.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb. 27 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 2-17, 1962, to 2-27, 1962

I last saw him alive on 2-27, 1962, death is said to have occurred on the date stated above, at 11:45 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) RITTER'S DISEASE

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? NO

What test confirmed diagnosis? OBSERVATION

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) Charles L. Brennan, M. D.
CHARLES G. BRENNAN
(PRINT OR TYPE SIGNATURE)

(Address) St. Elizabeth's Date 2-27 1962

6 Mt. Benedict Cemetery West Roxbury
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 2 1962

7 NAME OF FUNERAL DIRECTOR John J. Long

ADDRESS 360 Market St. Brighton

Received and filed MAR 27 1962 19

Charles F. Mackin
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male

9 COLOR White

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) single

10a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)

(or) WIFE of .....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE.....Years.....Months...8...Days If under 24 hours .....Hours.....Minutes

13 Usual Occupation: .....
(Kind of work done during most of working life)

14 Industry or Business: .....

15 Social Security No. .....

16 BIRTHPLACE (City) (State or country) Brighton

PARENTS

17 NAME OF FATHER Donald H. Colpak

18 BIRTHPLACE OF FATHER (City) (State or country) Winthrop

19 MAIDEN NAME OF MOTHER Claire Marie Walsh

20 BIRTHPLACE OF MOTHER (City) (State or country) Medford

21 Informant (Address) St. Elizabeth's Hospital Brighton

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

6071 3-1-62
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

OM R-301A

STRUCTIONS FOR AL CERTIFICATE

In giving UE OF DEATH

not enter re than one se for each), (b) and (c)

does not mean ode of dying, s heart failure, ea, etc. It means ease, or compli- which caused

itions, if any, h gave rise to e cause (a), ng the under- cause last.

nditions contrib- to death but not to the terminal condition given

60

ote:- Chapter 137, of 1954, requires sicians to print or the cause or es of death on h certificates, and pter 48, Acts of , requires Physi- s to print or type e under signature.

AY 8 - 1962

X OUT = OF = TOWN

62

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 02118

PLACE OF DEATH

1 Suffolk (County)

Boston (City or Town)

No. Beth Israel Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Rebecca (First Name) Possick (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Residence. No. 28 Pearl ~~Street~~ Ave St. Winthrop, Mass.
(Usual place of abode) (If nonresident give city or town and State)

Length of stay: In place of death ....years....months 1½ days. In place of residence ....years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March (Month) 1 (Day), 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1962 to ~~Feb.~~ March 1, 1962

I last saw her alive on March 1, 1962, death is said to have occurred on the date stated above, at 6:20 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Acute Pulmonary Edema	
Due To (b) Hypertensive Heart Disease	
Due To (c) Acute renal failure	
OTHER SIGNIFICANT CONDITIONS Chronic pyelonephritis	

Was autopsy performed? No

What test confirmed diagnosis? X-ray, Blood tests.

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify —

(Signed) Raymond C Yerkes M. D
RAYMOND C. YERKES
(PRINT OR TYPE SIGNATURE)

(Address) Beth Israel Hosp. Date Mar 1 1962

6 LINAS ATZEDEK EVERETT
Place of Burial or Cremation (City or Town)

DATE OF BURIAL 3-2- 1962

7 NAME OF FUNERAL DIRECTOR TORF CHAPELS

ADDRESS BROOKLINE

Received and filed MAR 2 1962 19....

Charles H. Mackie
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE

9 COLOR WHITE

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) WIDOWED

10a If married, widowed, or divorced HUSBAND of HARRY POSSICK
(Give maiden name of wife in full)

(or) WIFE of ....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 84 Years....Months....Days If under 24 hours ....Hours....Minutes

13 Usual Occupation: HOUSE WIFE
(Kind of work done during most of working life)

14 Industry or Business: OWN HOME

15 Social Security No. NONE

16 BIRTHPLACE (City) (State or country) RUSSIA

PARENTS

17 NAME OF FATHER AARON SHLILLER

18 BIRTHPLACE OF FATHER (City) (State or country) RUSSIA

19 MAIDEN NAME OF MOTHER C. BL.

20 BIRTHPLACE OF MOTHER (City) (State or country) RUSSIA

21 Informant ROSE PALMER
(Address) 28 PEARL AVE WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

6076 (Official Designation) 3-1-62 (Date of Issue of Permit)

X

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

ORM R-301

INSTRUCTIONS FOR ICAL CERTIFICATE

In giving SE OF DEATH

do not enter nore than one ause for each e(a), (b) and (c)

is does not mean mode of dying, as heart failure, nia, etc. It means disease, or campli- ns which caused h.

onditions, if any, hich gave rise to ove cause (a), ating the under- ing cause last.

Conditions contrib- g to death but not ted to the terminal ase condition given a).

Note:- Chapter 137, cts of 1954 requires hysicians to print or ype the cause or auses of death on eath certificates, and hapter 48, Acts of 959, requires Physi- ians to print or type ame under signature.

eral Directors ease use only LACK Ink.

MAY 8 - 1962

M 3-61-930213

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

63

To be filed for burial permit with Board of Health or its Agent.

Registered No. 02184

PLACE OF DEATH

1 SUFFOLK (County) — OUT OF TOWN

BOSTON (City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a U. S. War Veteran, if so specify WAR) no

2 FULL NAME Mary Terranova (Loggia)
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 247 Main Street St. Winthrop, Massachusetts
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months....days. In place of residence 21 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March (Month) 2 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from February 28, 1962 to March 2, 1962

I last saw or alive on March 2, 1962, death is said to have occurred on the date stated above, at 4:00 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Multiple metastasis of carcinoma	1 yr.
Due To (b) Carcinoma of the breast	4yrs
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Diabetes Mellitus	5yrs.

Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) C. L. Clay, M. D.
Charles L. Clay, M.D.
(Print or Type Name)
(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date March 2 1962

6 Winthrop Cemetery, Winthrop
Place of Burial or Cremation (City or Town)
DATE OF BURIAL March 5, 1962

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano
ADDRESS 147 Winthrop St., Winthrop

Received and filed MAR 6 1962 19....
Charles H. Mackie
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 CITIZEN OF U.S.	11 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN
female	white	YES ☐ NO ☐	WIDOWED ☒

11a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Joseph Terranova
(Husband's name in full)

12 DATE OF BIRTH July 25, 1889

13 AGE 72 Years....Months....Days — If under 24 hours ....Hours....Minutes

14 Usual Occupation: Retired Seamstress
(Kind of work done during most of working life)

15 Industry or Business: Garment

16 Social Security No. 029-10-2185

17 BIRTHPLACE (City) (State or country) Sicily

PARENTS

18 NAME OF FATHER Angelo Loggia

19 BIRTHPLACE OF FATHER (City) (State or country) Sicilly

20 MAIDEN NAME OF MOTHER Bernadette Marino

21 BIRTHPLACE OF MOTHER (City) (State or country) Sicily

22 Informant Joseph Terranova
(Address) 247 Main St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
F. P. Graca A 23796
(Signature of Agent of Board of Health or other)
(Official Designation) March 4 1962 (Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

OM R-301

IRUCTIONS
FOR
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giving
OF DEATH

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, (b) and (c)

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heart failure,
etc. It means
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which caused*

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gave rise to
cause (a),
the under-
cause last.*

*ditions contrib-
death but not
to the terminal
condition given*

450

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of 1954 requires
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certificates, and
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requires Physi-
to print or type
under signature.

AY 8 - 1962

3-61-930213

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

64

To be filed for burial permit
with Board of Health
or its Agent.

Registered No. 02359

OUT-OF-TOWN

1 PLACE OF DEATH
Suffolk (County)
Boston (City or Town)
xx Veterans Administration Hospital xx (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Benjamin (First Name) A. (Middle Name) Allan (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) III SAW

(a) Residence, No. 104 Highland Ave. (Usual place of abode) xx Winthrop, Mass. (If nonresident, give city or town and State)

Length of stay: In place of death 0 years 0 months 8 days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March (Month) 5 (Day) 1962 (Year) HA

4 I HEREBY CERTIFY, That I attended deceased from Feb. 25, 19 62, to Mar. 5, 19 62 xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx, death is said to have occurred on the date stated above, at 2:55 A. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Bilateral bronchopneumonia	days
Due To (b) Arteriosclerosis, generalized	yrs.
Due To (c) Right middle cerebral artery occlusion	wks.
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? Yes
What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) Herbert E. Rubin, M. D.
Herbert E. Rubin
(Print or Type Name)
(Address) VAH, Boston, Mass. Date Mar. 6 19 62

6 Long Island National Cem., L.I., N.Y.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL March 9, 1962 19.....

7 NAME OF FUNERAL DIRECTOR Robert J. Lawlor
ADDRESS 363 S. Huntington Ave., Boston, Mass.

Received and filed MAR 9 1962 19.....
Charles H. Mackie
(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 CITIZEN OF U.S.	11
Male	White	YES ☒ NO ☐	SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐ W

11a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

12 DATE OF BIRTH March 3, 1877

13 AGE 85 Years 0 Months 2 Days
If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: ..... (Kind of work done during most of working life)

15 Industry or Business: .....

16 Social Security No. .....

17 BIRTHPLACE (City) (State or country) Maine

PARENTS

18 NAME OF FATHER CNBL

19 BIRTHPLACE OF FATHER (City) (State or country) CNBL

20 MAIDEN NAME OF MOTHER CNBL

21 BIRTHPLACE OF MOTHER (City) (State or country) CNBL

22 Informant (Address) V. A. Hospital Records, 150 S. Huntington Ave., Boston 30, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

A. J. McNamara
(Signature of Agent of Board of Health or other)

6175
(Official Designation)

3-7-62
(Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles H. [illegible]

City Registrar

M R-301

RUCTIONS FOR CERTIFICATE

giving OF DEATH

not enter than one for each (b) and (c)

does not mean le of dying, heart failure, etc. It means ise, or compli- which caused

ions, if ony, gave rise to couse (a), the under- cause last.

ditions contrib- death but not to the terminal condition given

93.

:- Chapter 137, of 1954 requires icians to print or the cause or s of death on certificates, and ter 48, Acts of requires Physi- to print or type under signature.

AY 8 - 1962

3-61-930213

OUT-OF-TOWN

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

65

Registered No. 02304

PLACE OF DEATH

1 SUFFOLK (County)

ROXBURY (City or Town)

No. JEWISH MEMORIAL HOSPITAL St. {(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME SONIA (First Name) KALMAN (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 46 SAGAMORE ~~ST.~~ AVE St. WINTHROP, MASS.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 1 years 3 months 20 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH (Month) 6 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1960, to March 6, 1962

I last saw he alive on March 5, 1962, death is said to have occurred on the date stated above, at 3 40 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) PNEUMONIA

Due To (b)

Due To (c)

INTERVAL BETWEEN ONSET AND DEATH: 3 days

OTHER SIGNIFICANT CONDITIONS: ARTERIOSCLEROTIC HEART DISEASE, DIABETES MELLITUS

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify —

(Signed) Elie A. Horn, M. D.

ELIE A. HORN.
(Print or Type Name)

(Address) Jewish Memorial Hosp. Date 3-6 1962

6 Tifereth Israel Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL MARCH 7 1962

7 NAME OF FUNERAL DIRECTOR Torr Funeral Serv. Inc.

ADDRESS Washington Ave Chelsea

Received and filed MAR 7 1962 19

Charles H. Mackie (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Fem

9 COLOR: White

10 CITIZEN OF U.S. YES ☐ NO ☐

11 SINGLE ☐ MARRIED ☐ WIDOWED ☑ DIVORCED ☐ UNKNOWN ☐

11a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of LOUIS KALMAN
(Husband's name in full)

12 DATE OF BIRTH

13 AGE 59 Years Months Days — If under 24 hours Hours Minutes

14 Usual Occupation: Housewife
(Kind of work done during most of working life)

15 Industry or Business: Own Home

16 Social Security No. NONE

17 BIRTHPLACE (City) (State or country) Russia

PARENTS

18 NAME OF FATHER DAVID ARKIN

19 BIRTHPLACE OF FATHER (City) (State or country) Russia

20 MAIDEN NAME OF MOTHER Sophie TABLIN

21 BIRTHPLACE OF MOTHER (City) (State or country) Russia

22 Informant SAMUEL ARKIN
(Address) 55 QUINCY AVE WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Jacqueline Donato
(Signature of Agent of Board of Health or other)

6144 — 3/6/62
(Official Designation) (Date of Issue of Permit)

M R-301A

TRUCTIONS FOR L CERTIFICATE

n giving E OF DEATH

not enter e than one se for each), (b) and (c)

does not mean ode of dying, s heart failure, n, etc. It means ease, or compli- which caused

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nditions contrib- o death but not to the terminal condition given

- Chapter 137, 1954, requires ans to print or he cause or of death on rtificates, and 48, Acts of quires Physi- print or type nder signature.

AY 8 - 1962

-11-59-926662

The Commonwealth of Massachusetts

66

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 02467

PLACE OF DEATH

1 (County) SUFFOLK = TOWN

(City or Town) EAST BOSTON

No. PRINCTON Shelby NURSING HOME St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME MARY A. (MC GUNNIGLE) MAC DONALD (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, (if so specify WAR) No

(a) Residence. No. 81 SUNNYSIDE AVE St. WINTHROP - MASS. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months 21 days. In place of residence 5 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAR (Month) 9 (Day) 1962 (Year)

4 I HEREBY CERTIFY. That I attended deceased from JAN 12, 1962, to MAR 9, 1962

I last saw h. alive on MAR 9, 1962, death is said to have occurred on the date stated above, at 12:15 A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) ARTERIO-SCLEROTIC HEART DIS	6 mo.
Due To (b) GENERAL ARTERIOSCLEROSIS	5 YRS.
Due To (c)	
OTHER SIGNIFICANT CONDITIONS MYXEDEMA GLAUCOMA	5 YRS

Was autopsy performed? No.

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No. If so, specify

(Signed) Myron N. King, M. D.

MYRON N. KING M.D (PRINT OR TYPE SIGNATURE)

(Address) 244 CLEASANT ST. WINTHROP Date 3/9 1962

6 CALVARY BROCKTON Place of Burial or Cremation (City or Town)

DATE OF BURIAL MARCH 12, 1962

7 NAME OF FUNERAL DIRECTOR JAMES F. HICKEY

ADDRESS 403 MAIN ST. BROCKTON

Received and filed MAR 12 1962 19..

Charles F. Mackie (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female

9 COLOR White

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) WIDOWED

10a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of DUNCAN D. MAC DONALD (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 80 Years 3 Months 7 Days If under 24 hours ....Hours....Minutes

13 Usual Occupation: AT HOME (Kind of work done during most of working life)

14 Industry or Business: NONE

15 Social Security No. NONE

16 BIRTHPLACE (City) BUFFALO (State or country) NEW YORK

PARENTS

17 NAME OF FATHER WILLIAM MC GUNNIGLE

18 BIRTHPLACE OF FATHER (City) BOSTON - MASS (State or country)

19 MAIDEN NAME OF MOTHER MARY MC CALLOUGH

20 BIRTHPLACE OF MOTHER (City) BROCKTON - MASS. (State or country)

21 Informant MRS. JAMES MC KENNA (Address) 81 SUNNYSIDE AVE. WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

J. Donat (Signature of Agent of Board of Health or other)

6223 (Official Designation) 3/9/62 (Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

M R-301A

TRUCTIONS FOR AL CERTIFICATE

n giving E OF DEATH

not enter re than one se for each), (b) and (e)

does not mean ode of dying, s heart failure, n, etc. It means ease, or compli- which caused

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nditions contrib- ta death but not to the terminal condition given

180

m.c.

ote:- Chapter 137, of 1954, requires sicians to print or the cause or es of death on h certificates, and pter 48, Acts of , requires Physi- s to print or type e under signature.

AY 8 - 1962

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

67

To be filed for burial permit with Board of Health or its Agent.

Registered No. 02481

1 PLACE OF DEATH: SUFFOLK (County) ROXBURY (City or Town) No. JEWISH MEMORIAL HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

Louis Witten

2 FULL NAME LOUIS WITTEN (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence, No. 117 SHORE DRIVE St. WINTHROP, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MARCH 10 1962 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from FEBRUARY 7, 1962, to MARCH 10, 1962. I last saw him alive on MARCH 10, 1962, death is said to have occurred on the date stated above, at 6:30 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) HYPERNEPHROMA WITH

Due To (b) METASTASES — MONTHS

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No
What test confirmed diagnosis? CLINICAL, OPERATION

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify NONE

(Signed) Shanta Sherring M. D
SHANTA SHERRING M.D
(PRINT OR TYPE SIGNATURE)
(Address) JEWISH MEMORIAL HOSPITAL Date MARCH 10 1962

6 Shara Tfilo (Lebanon) W. Roxbury
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 11, 1962

7 NAME OF FUNERAL DIRECTOR Benjamin F. Solomon

ADDRESS 420 Harvard St., Brookline.

Received and filed MAR 13 1962 19.....
Charles H. Mackie (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male

9 COLOR white

10 SINGLE, MARRIED, WIDOWED, or DIVORCED (write the word) married

10a If married, widowed, or divorced HUSBAND of Bertha Badanes
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 79 Years.....Months.....Days — If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Salesman (retired)
(Kind of work done during most of working life)

14 Industry or Business: Dry Goods

15 Social Security No. 010-07-4376

16 BIRTHPLACE (City) (State or country) Russia

PARENTS

17 NAME OF FATHER Carl Witten

18 BIRTHPLACE OF FATHER (City) (State or country) Russia

19 MAIDEN NAME OF MOTHER Sarah (unknown)

20 BIRTHPLACE OF MOTHER (City) (State or country) Russia

21 Informant Robert Witten
(Address) 209 Winchester St., Brooklin

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
F. L. Draco A 23478
(Signature of Agent of Board of Health or other)
(Official Designation) March 10, 1962 (Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

RM R-303

PLACE OF DEATH

1 SUFFOLK (County)

BOSTON (City or Town)

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

68

Registered No. 02577

No. ..... St. Massachusetts General Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME MARY BRESLIN
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 115 St. Washington Avenue, (If nonresident, give city or town and State) Winthrop, Mass.
(Usual place of abode)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March (Month) 11, (Day) 1962 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Coronary thrombosis and myocardial infarction following fracture of femur.

5 Accident, suicide, or homicide (specify) Accident

Date and hour of injury February 28, 19 62

IF ACCIDENTAL, was injury causally related to the death? Yes.

Where did Injury occur? Winthrop, Mass. (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? Home. (Specify type of place)

Manner of Injury Fall (How did injury occur?) Floor.

Nature of Injury Fracture of femur

While at work? ..... Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) Michael J. Luongo, M. D.

Michael J. Luongo, M.D. (Print or type Name) 3/12 62

(Address) Boston Date 19

7 Place of Burial or Cremation. Mt. Cavalry Malden (City or Town)

DATE OF BURIAL March 14 1962

8 NAME OF FUNERAL DIRECTOR James F. Lynch

ADDRESS 1209 Park St. Dorchester

Received and filed MAR 14 1962 19

Charles H. Mackie (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 CITIZEN OF U.S.	12 SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐
Female	White	YES ☑ NO ☐	

12a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

13 DATE OF BIRTH April 12 1881

14 AGE 80 Years ..... Months ..... Days If under 24 hours ..... Hours ..... Minutes

15 Usual Occupation: Ret. Cafeteria Manager (Kind of work done during most of working life)

16 Industry or Business: Federal Bldg. Boston

17 Social Security No. 031-01-5529

18 BIRTHPLACE (City) (State or country) Boston

PARENTS

19 NAME OF FATHER Michael Breslin

20 BIRTHPLACE OF FATHER (City) (State or country) Ireland

21 MAIDEN NAME OF MOTHER Mary English

22 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

23 Informant Thomas Curry (Cousin)
(Address) 38 Wedge St. Malden

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Gill Rennell AZ016
(Signature of Agent of Board of Health or other)

(Official Designation) MAR 12 1962 (Date of Issue of Permit)

B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-3-61-930213

903

MAY 8 - 1962

CANCELLED

A TRUE COPY ATTEST:

Charles H. Jenckie

City Registrar

DM R-302

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-2-59-922072

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

NEWTON (City or Town making this return)

Registered No. 141-62 69

1 PLACE OF DEATH
MIDDLESEX (County)
NEWTON (City or Town)
No. Buswell Park Nursing Home 7 Buswell Park, Newton St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Orland (Nickerson) Stabb
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. Unknown St. Winthrop Mass
(Usual place of abode) unknown (If nonresident, give city or town and State)

Length of stay: In place of death 10 years ..... months ..... days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Mar (Month) 13 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Aug 5, 1960 to Mar 13, 1962

I last saw her alive on Mar 12, 1962, death is said to have occurred on the date stated above, at 11:45 A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Arterio sclerosis of cerebral arteries — 10 yrs

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS Pneumonia left lung — 4 days

Was autopsy performed? No
What test confirmed diagnosis? Clin Observation

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Joseph R Cotter, M. D.
(Address) 1155 Boylston St Newton Mass Date 13 Mar 1962

6 Place of Burial or Cremation Evergreen Cem Leominster Mass (City or Town)
DATE OF BURIAL March 15, 1962

7 NAME OF FUNERAL DIRECTOR Rober T. Perkins
ADDRESS 30 Prospect St Waltham

Received and filed MAY 4 - 1962
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female
9 COLOR White
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Widowed

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Arthur Stabb
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 84 Years 1 Months 17 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No. None

16 BIRTHPLACE (City) Leominster
(State or country) Mass

PARENTS

17 NAME OF FATHER David C Nickerson

18 BIRTHPLACE OF FATHER (City) Leominster
(State or country) Mass

19 MAIDEN NAME OF MOTHER Helena Chase

20 BIRTHPLACE OF MOTHER (City) Leominster
(State or country) Mass

21 Informant Mrs. Nathan A. Tufts Sr
(Address) 514 Pitman Ave Pitman N J

A TRUE COPY
ATTEST: Monte R. Bosbas
(Registrar of City or Town where death occurred)

DATE FILED March 14, 1962

R-301A

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Y 8 - 1962

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The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT - OF - TOWN

To be filed for burial permit with Board of Health or its Agent.

70

Registered No. 02697

1 PLACE OF DEATH: Suffolk (County) — Boston (City or Town) — No. New England Baptist Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Mrs Verna (First Name) (Coffin) (Middle Name) Douglas (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 3 Buckthorn Terrace St. Winthrop Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months 11 days. In place of residence 58 years 2 months 7 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March (Month) 14 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from March 4, 1962, to March 14, 1962.
I last saw her alive on March 14, 1962, death is said to have occurred on the date stated above, at 6:35 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Uremia due to metastatic Disease — 11 Mo
Due To (b) Metastatic Disease — 6+ Mos
Due To (c) Ca of Colon — 7 Yrs
OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? Yes
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) ELMER C. BARTELS, M. D.
Elmer C. Bartels (PRINT OR TYPE SIGNATURE)
(Address) 605 Commonwealth Ave 3-14 1962

6 Winthrop (Place of Burial or Cremation) Winthrop (City or Town)
DATE OF BURIAL March 17 1962

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds
ADDRESS Winthrop Mass

Received and filed MAR 16 1962 19
Charles H. Mackie (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Married

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of L Eugene Douglas
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 58 Years 2 Months 7 Days — If under 24 hours ....Hours....Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own home

15 Social Security No. None

16 BIRTHPLACE (City) Winthrop
(State or country) Mass

PARENTS

17 NAME OF FATHER George Coffin

18 BIRTHPLACE OF FATHER (City)
(State or country) Prince Edward Island

19 MAIDEN NAME OF MOTHER Minnie Boyd

20 BIRTHPLACE OF MOTHER (City) Moncton
(State or country) New Brunswick

21 Informant L Eugene Douglas
(Address) 3 Buckthorn Terr. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)
6314 (Official Designation) 3-15-62 (Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

R-303

X

1 PLACE OF DEATH: SUFFOLK (County) BOSTON (City or Town)

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

OUT - OF - TOWN

To be filed for burial permit with Board of Health or its Agent.

71

Registered No. 028332

No. En route to Massachusetts General Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME MARY E. FARRELL (EASTMAN)
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Residence. No. 37 Pebble Avenue St. Winthrop, Massachusetts
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months....days. In place of residence 45 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March (Month) 16, (Day) 1962 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Acute pulmonary edema.
Arteriosclerotic heart disease.

5 Accident, suicide, or homicide (specify)

Date and hour of injury ....19..

IF ACCIDENTAL, was injury causally related to the death?

Where did Injury occur? (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)

Manner of Injury (How did injury occur?)

Nature of Injury

While at work? Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Michael A. Lungo, M. D.
(Print or Type Name)

(Address) Boston Date 3/17 1962

7 WINTHROP Place of Burial, or Cremation. WINTHROP (City or Town)

DATE OF BURIAL MARCH 19 1962

8 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY

ADDRESS WINTHROP

Received and filed MAR 20 1962 19..

A TRUE COPY ATTEST: Charles H. Mackie (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 CITIZEN OF U.S.	12 SINGLE ☐ MARRIED ☐ WIDOWED ☒ DIVORCED ☐ UNKNOWN ☐
FEMALE	WHITE	YES ☒ NO ☐	

12a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of BERNARD F. FARRELL
(Husband's name in full)

13 DATE OF BIRTH SEPT 6 1885

14 AGE 76 Years....Months....Days If under 24 hours ....Hours....Minutes

15 Usual Occupation: HOME MAKER
(Kind of work done during most of working life)

16 Industry or Business: HOME

17 Social Security No. NONE

18 BIRTHPLACE (City) BOSTON
(State or country) MASS

PARENTS

19 NAME OF FATHER GEORGE T. EASTMAN

20 BIRTHPLACE OF FATHER (City)
(State or country) ENGLAND

21 MAIDEN NAME OF MOTHER ELLEN SULLIVAN.

22 BIRTHPLACE OF MOTHER (City) IRELAND
(State or country)

23 Informant MRS EVERLYN PORTER
(Address) 1079 SHIRLEY ST WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

6340 3-19-62
(Official Designation) (Date of Issue of Permit)

FILED COPY

Information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-3-61-930213

M.C.

Apr 1962

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

R-301A

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8 - 1962

59-925686

X

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT - OF - TOWN 72

To be filed for burial permit with Board of Health or its Agent.

Registered No. 029952

1 PLACE OF DEATH: Suffolk (County); Boston (City or Town); No. Massachusetts General Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

2 FULL NAME: Bernard Delaney
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence No. 26 Sturges Street St. Winthrop, Massachusetts
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months....days. In place of residence 10 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: March (Month) 20 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from March 20, 1962, to March 20, 1962, I last saw him alive on March 20, 1962, death is said to have occurred on the date stated above, at 3:20 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Coronary Heart Disease	15 yrs
Due To (b) Arteriosclerosis body Generally	unk yrs
Due To (c)	
OTHER SIGNIFICANT CONDITIONS: Status Asthmaticus	unk yrs

Was autopsy performed? yes
What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased? ....
If so, specify ....

(Signed) C. L. Clay, M. D.
Charles L. Clay, M.D.
(PRINT OR TYPE SIGNATURE)
(Address) Ass't.Dir.Mass.Gen'l Hosp. Date March 20,62 19..

6 Place of Burial or Cremation: Winthrop Cemetery (City or Town) Winthrop
DATE OF BURIAL March 23, 19 62

7 NAME OF FUNERAL DIRECTOR: Ernest P. Caggiano
ADDRESS 147 Winthrop St., Winthrop

Received and filed MAR 23 1962 19..
Charles H. Mackie (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: male
9 COLOR: white
10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): divorced

10a If married, widowed or divorced, HUSBAND of Rose Schultz
(Give maiden name of wife in full)
(or) WIFE of ....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 62 Years....Months....Days. If under 24 hours ....Hours....Minutes

13 Usual Occupation: cook
(Kind of work done during most of working life)

Industry or Business: restaurant

15 Social Security No. 031-07-8067

16 BIRTHPLACE (City) Lydonville (State or country) Vermont

PARENTS

17 NAME OF FATHER: John Delaney

18 BIRTHPLACE OF FATHER (City) Lydonville (State or country) Vermont

19 MAIDEN NAME OF MOTHER: Helen ?

20 BIRTHPLACE OF MOTHER (City) ? (State or country)

21 Informant: Hugh Murphy
(Address) 72 Chestnut St., N. Reading

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

R. J. Kassman
(Signature of Agent of Board of Health or other)

6/13 (Official Designation) 3-22-62 (Date of Issue of Permit)

T. V.B.V.

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

M R-301A

STRUCTIONS FOR AL CERTIFICATE

In giving E OF DEATH

not enter re than one se for each), (b) and (c)

does not mean ode of dying, heart failure, , etc. It means ease, or compli- which caused

itions, if any, h gave rise to e cause (a), g the under- cause last.

nditions contrib- o death but not to the terminal condition given

- Chapter 137, 1954, requires ians to print or he cause or of death on ertificates, and r 48, Acts of equires Physi- o print or type nder signature.

1-11-59-926662

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 73

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. WINTHROP COM HOSP St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Frederick A. Mulloney (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Residence. No. 5 Loring Road, Winthrop St. (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death ....years....months....2 days. In place of residence 59 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April (Month) 9, (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov., 1955, to April 9, 1962

I last saw him alive on April 9, 1962, death is said to have occurred on the date stated above, at 7:00 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 days

Due To (b) Arteriosclerotic Heart Disease — 7 yrs.

Due To (c)

OTHER SIGNIFICANT CONDITIONS None

Was autopsy performed? No

What test confirmed diagnosis? Clinical and Laboratory

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) M. Traunstein Jr., M. D.

M. Traunstein, Jr., M.D.
(PRINT OR TYPE SIGNATURE)

(Address) 73 Bartlett Road, Winthrop Date April 9 1962

6 WINTHROP Place of Burial or Cremation WINTHROP (City or Town)

DATE OF BURIAL APRIL 12 1962

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY

ADDRESS 210 WINTHROP ST WINTHROP

Received and filed APR 10 1962 1962 (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: MALE

9 COLOR: WHITE

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word): SINGLE

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 59 Years....Months....Days — If under 24 hours ....Hours....Minutes

13 Usual Occupation: STATISTICIAN (Kind of work done during most of working life)

14 Industry or Business: INVESTMENT

15 Social Security No. 011-05-7973

16 BIRTHPLACE (City) BOSTON (State or country) MASS

PARENTS

17 NAME OF FATHER THOMAS A MULLONEY

18 BIRTHPLACE OF FATHER (City) BOSTON (State or country) MASS

19 MAIDEN NAME OF MOTHER MARGARET A CHAEFER

20 BIRTHPLACE OF MOTHER (City) BOSTON (State or country) MASS

21 Informant GRACE M HASKELL
(Address) 5 LORING RD WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph C. Stevens M.D.
(Signature of Agent of Board of Health or other)

Health Officer 4/10/62
(Official Designation) (Date of Issue of Permit)

August Take ... I.

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R-303

information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-3-61-930213

PLACE OF DEATH

1 SUFFOLK (County)

WINTHROP (City or Town)

Malden

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 74

En route to Winthrop Community Hospital
No. ..... St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME ELLEN DAVIDSON
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 44 Sprague Street St. Malden, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years 7 months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April (Month) 11 (Day), 1962 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Coronary occlusion.
Hypertensive cardio-vascular disease.

5 Accident, suicide, or homicide (specify) .....

Date and hour of injury .....19.....

IF ACCIDENTAL, was injury causally related to the death? .....

Where did Injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)

Manner of Injury ..... (How did injury occur?)

Nature of Injury .....

While at work? ..... Was autopsy performed? .....

6 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) Michael A. Mongo, M. D.
Michael A. Mongo, M.D.
(Print or type Name)

(Address) Boston Date 4/11 1962

7 Holy Cross Malden
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL April 14 1962

8 NAME OF FUNERAL DIRECTOR Frederick J. MacGrath

ADDRESS East Boston

Received and filed APR 13 1962 19.....

A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 CITIZEN OF U.S.	12 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN
Female	White	YES ☑ NO ☐	☐ ☑ ☐ ☐ ☐

12a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Joseph J. DAVIDSON
(Husband's name in full)

13 DATE OF BIRTH Sept 14, 1903

14 AGE 58 Years 5 Months ..... Days. If under 24 hours .....Hours .....Minutes

15 Usual Occupation: House ~~work~~ WIFE
(Kind of work done during most of working life)

16 Industry or Business: Own Home

17 Social Security No. C.N.B.L.

18 BIRTHPLACE (City) EAST BOSTON
(State or country) MASS.

PARENTS

19 NAME OF FATHER Michael O'MEARA

20 BIRTHPLACE OF FATHER (City) .....
(State or country) Ireland

21 MAIDEN NAME OF MOTHER MARY HANLON

22 BIRTHPLACE OF MOTHER (City) .....
(State or country) Ireland

23 Informant Joseph J. DAVIDSON
(Address) 44 SPRAGUE ST. MALDEN

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph C. Lorenzo
(Signature of Agent of Board of Health or other)

Health Officer 4/13/62
(Official Designation) (Date of Issue of Permit)

MEDICAL

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

ORM R-302

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

X

The Commonwealth of Massachusetts

75

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Somerville
(City or Town making this return)

Registered No. 231

1 PLACE OF DEATH
Middlesex (County)
Somerville (City or Town)
Little Sisters of the Poor
No. 186 Highland Avenue St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME William J. Murphy
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR, ---

(a) Residence. No. 163 Sewall Avenue St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death - years 2 months 14 days. In place of residence 14 years - months - days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April (Month) 14, (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 6/2/61, 19..., to 4/14, 19..., 1962
I last saw him alive on 4/12, 1962 death is said to have occurred on the date stated above, at 9:00A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

	INTERVAL BETWEEN ONSET AND DEATH
(a) Cerebral Hemorrhage	3 days
Due To (b) Gen'l Arteriosclerosis	3 yrs
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Hypostatic broncho pneumonia	1d

Was autopsy performed?
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? --
If so, specify

(Signed) Thomas A. Kelley, M. D.
(Address) 52 Central Street Somerville, Mass Date 4-16 1962

6 Place of Burial or Cremation Oak Grove Cem. (City or Town) Medford, Mass.
DATE OF BURIAL Apr. 17 1962

7 NAME OF FUNERAL DIRECTOR Edmund L. Kelleher
ADDRESS 67 Broadway, Somerville

Received and filed MAY 2 - 1962 19...
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: white
10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: Widowed

11 If married, widowed, or divorced
HUSBAND of Bridget Anne Lynch
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 84 Years - Months - Days
If under 24 hours Hours Minutes

13 Usual Occupation: Storekeeper-Retired
(Kind of work done during most working life)

14 Industry or Business: Storekeeper-own business

15 Social Security No. - - - - - - -

16 BIRTHPLACE (City)
(State or country) Ireland

PARENTS

17 NAME OF FATHER C.N.B.L.

18 BIRTHPLACE OF FATHER (City)
(State or country) Ireland

19 MAIDEN NAME OF MOTHER C.N.B.L.

20 BIRTHPLACE OF MOTHER (City)
(State or country) Ireland

21 Informant S. Xavier
(Address) 186 Highland Ave. Somerville

A TRUE COPY William J. Donovan
ATTEST:
(Registrar of City or Town where death occurred)

DATE FILED Apr. 17 1962

M.C.

X

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

ORM R-301

for burial permit
oard of Health
its Agent.

RUCTIONS
FOR
L CERTIFICATE

T OR TYPE
S OR CAUSES
DEATH

not enter
e than one
e for each
, (b) and (c)

does not mean
de of dying,
heart failure,
etc. It means
ase, or compli-
which caused

ions, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
to the terminal
condition given

C.

PR 18 1962

62-932382

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 76

PLACE OF DEATH
1 Suffolk (County)
Winthrop (City or Town)
No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Myer Kumins
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 329 A Shirley St. Winthrop Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months 7 days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April (Month) 17 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan., 1956 to April 17, 1962
I last saw him alive on April 17, 1962, death is said to have occurred on the date stated above, at 8:00 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Lymphosarcoma — INTERVAL BETWEEN ONSET AND DEATH 8 wks.

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS None

Was autopsy performed? No
What test confirmed diagnosis? Clinical, Pathological

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) Winthrop, Mass. Date 4/17/1962

6 Tifereth Israel of Winthrop Everett
Place of Burial or Cremation (City or Town)
DATE OF BURIAL April 18, 1962

7 NAME OF FUNERAL DIRECTOR Benjamin Birnbach
ADDRESS 1668 Beacon St Brookline

Received and filed .....19.....
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: Single

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 AGE 50 Years.....Months.....Days — If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Painter
(Kind of work done during most working life)

14 Industry or Business: Smithcraft Fixture Co

15 Social Security No. 030-07-6334

16 BIRTHPLACE (City) (State or country) Boston Mass

PARENTS
17 NAME OF FATHER Simon Kuming
18 BIRTHPLACE OF FATHER (City) (State or country) Russia
19 MAIDEN NAME OF MOTHER Fanny Sherman
20 BIRTHPLACE OF MOTHER (City) (State or country) Russia

21 Informant Albert Kuming
(Address) 31 Hawthorne Ave Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Ralph E. Sweeney
(Signature of Agent of Board of Health or other)
Health Officer 4/18/62
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

M R-301A

TRUCTIONS FOR L CERTIFICATE

n giving : OF DEATH

d not enter e than one e for each , (b) and (c)

does not mean de of dying, heart failure, etc. It means ase, or compli- which caused

ions, if any, gave rise to cause (a), the under- cause last.

ditions contrib- death but not to the terminal condition given

Chapter 137, 1954, requires ns to print or e cause or of death on rtificates, and 48, Acts of quires Physi- print or type der signature.

50-11-59-926662

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 77

1 PLACE OF DEATH — X

Suffolk (County)

Winthrop (City or Town)

No. 47 Sunnyside Ave. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME JOSEPH I. CANAVAN
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No. 47 Sunnyside Ave. St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 3 years ... months ... days. In place of residence 3 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April (Month) 19, (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...

I last saw h... alive on ..., 19..., death is said to have occurred on the date stated above, at 3 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death due to natural causes, presumably acute coronary occlusion, ~~due to~~ known

Due to (b) arteriosclerotic and

Due To (c) coronary artery heart disease.

Winthrop Board of Health

OTHER SIGNIFICANT CONDITIONS Charles Liberman M.D.

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? ...

What test confirmed diagnosis? ...

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify ...

(Signed) Charles Liberman, M. D.
CHARLES LIBERMAN
(PRINT OR TYPE SIGNATURE)

(Address) WINTHROP Date 4/19/1962

6 Holy Cross Cemetery, Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 23, 1962

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano
ADDRESS 147 Winthrop St., Winthrop

Received and filed APR 23 1962 19...
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male

9 COLOR white

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word) married

10a If married, widowed, or divorced
HUSBAND of Catherine D. Smith
(Give maiden name of wife in full)

(or) WIFE of ...
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 70 Years 4 Months 12 Days
If under 24 hours ... Hours ... Minutes

13 Usual Occupation: Retired Fire Lieutenant
(Kind of work done during most of working life)

14 Industry or Business: Boston Fire Dept.

15 Social Security No. ...

16 BIRTHPLACE (City) Boston
(State or country) Mass.

PARENTS

17 NAME OF FATHER Patrick J. Canavan

18 BIRTHPLACE OF FATHER (City) ...
(State or country) Ireland

19 MAIDEN NAME OF MOTHER Emma L. Dubberley

20 BIRTHPLACE OF MOTHER (City) ...
(State or country) Nova Scotia

21 Informant Mrs. Catherine D. Canavan
(Address) 47 Sunnyside Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph C. Leclaire
(Signature of Agent of Board of Health or other)

Health Officer 4/23/62
(Official Designation) (Date of Issue of Permit)

Original Taken ... L.E.M.

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R-301A

UCTIONS
OR
CERTIFICATE

giving
OF DEATH

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of dying,
heart failure,
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Chapter 137,
954, requires
s to print or
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ificates, and
48, Acts of
uires Physi-
print or type
er signature.

-59-925686

The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 78

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. 5 Irwin St. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Walter T. Glassett (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No. 5 Irwin (Usual place of abode) St. Winthrop (If nonresident, give city or town and State)

Length of stay: In place of death 2 years months days. In place of residence 2 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 20, 1962 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from —, 19—, to —, 19—.

I last saw h— alive on —, 19—, death is said to have occurred on the date stated above, at 2:10 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Natural Causes —

Due To (b) Presumably Coronary Odclusion — sudden

Due To (c) Arteriosclerotic Heart Disease — 5 years

OTHER SIGNIFICANT CONDITIONS none

Was autopsy performed? no

What test confirmed diagnosis? post-mortem judgement

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Arthur C. Murray, M. D.

Arthur C. Murray (PRINT OR TYPE SIGNATURE)

(Address) Winthrop Board of Health Date 23 April 1962

6 Holy Cross Cemetery, Malden

Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 24, 1962

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 147 Winthrop St., Winthrop

Received and filed APR 25 1962 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male

9 COLOR white

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) widowed

10a If married, widowed, or divorced HUSBAND of Catherine Foley (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 69 Years Months Days — If under 24 hours Hours Minutes

13 Usual Occupation: Supervisor (Kind of work done during most of working life)

14 Industry or Business: Submarine Signal

15 Social Security No.

16 BIRTHPLACE (City) Everett (State or country) Mass.

PARENTS

17 NAME OF FATHER Thomas Glassett

18 BIRTHPLACE OF FATHER (City) East Boston (State or country) Mass

19 MAIDEN NAME OF MOTHER Elizabeth Whalen

20 BIRTHPLACE OF MOTHER (City) East Boston (State or country) Mass

21 Informant Walter T. Glassett Jr. (Address) 59 Beal St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Arthur C. Murray (Signature of Agent of board of Health or other)

Health Officer (Official Designation) 4/27/62 (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following les of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

ORM R-302

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12. G. L.)

50M-9-59-926111

X

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Revere
(City or Town making this return)

Registered No. 79

1 PLACE OF DEATH

Suffolk
(County)

Revere
(City or Town)

No. Annemark Nursing Home x. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Israel Rantz
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 19 Underhill St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 13 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April (Month) 23, (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Aug. 23, 1961, to April 23, 1962

I last saw him alive on April 23, 1962, death is said to have occurred on the date stated above, at 6:30A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary Thrombosis

Due To (b) Arteriosclerotic Ht. Dz.

Due To (c) Generalized Arteriosclerosis

OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH: 10yr. / 20yrs.

Was autopsy performed? No
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Morris I. Sacks M. D.
(Address) 45 Shirley Ave. Revere Date Apr.23, 1962

6 Workmens Circle Melrose, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL April 24, 1962

7 NAME OF FUNERAL DIRECTOR Morris Brezniak
ADDRESS 470 Harvard St., Brookline

Received and filed MAY 10 1962
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Married

10a If married, widowed, or divorced HUSBAND of Bessie Freeman
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 82 Years.....Months.....Days. If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Retired
(Kind of work done during most of working life)

14 Industry or Business: Tailor

15 Social Security No.

16 BIRTHPLACE (City) (State or country) Russia

PARENTS

17 NAME OF FATHER Kpel Rantz

18 BIRTHPLACE OF FATHER (City) (State or country) Russia

19 MAIDEN NAME OF MOTHER Gussie (Cannot be learned)

20 BIRTHPLACE OF MOTHER (City) (State or country) Russia

21 Informant Lester Henry
(Address) 71 Beal St., Winthrop, Mass.

A TRUE COPY
ATTEST: [signature]
(Registrar of City or Town where death occurred)

DATE FILED April 24, 1962

V. 13V

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

DM R-301A

INSTRUCTIONS FOR FILL CERTIFICATE

n giving S OF DEATH

d not enter e than one e for each (a), (b) and (c)

does not mean de of dying, heart failure, etc. It means ause, or compli- which caused

ions, if any, gave rise to cause (a), the under- cause last.

Conditions contrib- death but not to the terminal condition given a)

c.

:- Chapter 137, of 1954, requires ycians to print or the cause or s of death on certificates, and er 48, Acts of 59 requires Physi- to print or type under signature.

4-60-928145

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 80

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. South Convalescent Home St. {(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME George F Patch (First Name) (Middle Name) (Last Name) {(Was deceased a U. S. War Veteran, if so specify WAR)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 104 Highland Ave. St.
(Usual place of abode) 2 3 (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 25 1962 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from June, 1933, to April 25, 1962

I last saw him alive on April 24, 1962, death is said to have occurred on the date stated above, at 8:10 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Myocardial Heart Disease — yrs

Due To (b) Arteriosclerosis gen. — yrs

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No.
If so, specify

(Signed) Joseph Gregoire, M. D.
Joseph Gregoire
(PRINT OR TYPE SIGNATURE)

(Address) 194 Washington Ave Date April 27 1962

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 27 1962

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds
Winthrop Mass
ADDRESS

Received and filed APR 26 1962 19.....
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male

9 COLOR White

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Widowed

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 33 Years 2 Months 1 Days — If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Route Salesman
(Kind of work done during most of working life)

14 Industry or Business: Milk

15 Social Security No. [illegible]

16 BIRTHPLACE (City) Cohrain
(State or country) Mass.

PARENTS

17 NAME OF FATHER George Patch

18 BIRTHPLACE OF FATHER (City) Unable to obtain
(State or country)

19 MAIDEN NAME OF MOTHER Josephine Tewksbury

20 BIRTHPLACE OF MOTHER (City) Unable to obtain
(State or country)

21 Informant Records Old Age Bureau
(Address) Town of Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sirrianni
(Signature of Agent of Board of Health or other)

Health Officer 4/26/62
(Official Designation) (Date of Issue of Permit)

T.V.V.

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

1 R-301A

RUCTIONS FOR G. CERTIFICATE

giving S OF DEATH

do not enter more than one space for each (b) and (c)

does not mean mode of dying, heart failure, etc. It means disease, or complication which caused

tions, if any, gave rise to cause (a), the underlying cause last.

Additions contributing death but not to the terminal condition given

Chapter 137, 1954, requires ons to print or the cause or of death on certificates, and 48, Acts of requires Physi- print or type under signature.

-6-59-925686

The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 81

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. 26 Centre St. St. {(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Mary G. Cushing {(Was deceased a U. S. War Veteran, (if so specify WAR) No
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 26 Centre Street St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years ....months ....days. In place of residence 30 years ....months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 29, 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from June, 1960 to April 29, 1962
I last saw her alive on April 29, 1962, death is said to have occurred on the date stated above, at 5:45 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Coronary Occlusion, acute	6hrs.
Due To (b) Hypertension	3yrs
Due To (c) Arteriosclerotic Heart DISEASE	3yrs
OTHER SIGNIFICANT CONDITIONS None	

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signed) Charles Liberman, M. D.
CHARLES LIBERMAN
(PRINT OR TYPE SIGNATURE)
(Address) WINTHROP, Date 4/30/1962

6 Holy Cross Malden, Mass
Place of Burial or Cremation (City or Town)
DATE OF BURIAL May 2, 1962

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
ADDRESS Winthrop Mass

Received and filed MAY 1 - 1962 19....
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female
9 COLOR White
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Married

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Joseph Cushing
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 78 Years ....Months ....Days
If under 24 hours ....Hours ....Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No.

16 BIRTHPLACE (City) East Boston
(State or country) Mass

PARENTS

17 NAME OF FATHER George G. Brennan

18 BIRTHPLACE OF FATHER (City) St. John
(State or country) N. B.

19 MAIDEN NAME OF MOTHER Mary L. McDonald

20 BIRTHPLACE OF MOTHER (City) East Boston
(State or country) Mass

21 Informant Joseph Cushing
(Address) 26 Centre St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Ralph C. Sorrento
(Signature of Agent of Board of Health or other)
Health Officer 5/1/62
(Official Designation) (Date of Issue of Permit)

V.R.

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following les of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

Fill for burial permit
Board of Health
its Agent.

INSTRUCTIONS
FOR
FULL CERTIFICATE

PRINT OR TYPE
ES OR CAUSES
OF DEATH

not enter
e than one
se for each
, (b) and (c)

does not mean
de of dying,
heart failure,
, etc. It means
ase, or compli-
which caused

tions, if any,
gave rise to
cause (a),
the under-
cause last.

Conditions contrib-
death but not
to the terminal
condition given

M. C.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 82

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Story (If deceased is a married, widowed or divorced woman, give also maiden name.) Frank S.

(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No. 19 Frances St. (Usual place of abode) St. Winthrop, Mass. (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months..1.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April (Month) 30 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec 4, 1958, to April 30, 1962

I last saw him alive on 4-3-9, 1962, death is said to have occurred on the date stated above, at 1040 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Congestive heart failure

Due To (b) arteriosclerotic heart dis.

Due To (c)

OTHER SIGNIFICANT CONDITIONS None

INTERVAL BETWEEN ONSET AND DEATH: 4 yrs.

Was autopsy performed? NO

What test confirmed diagnosis? Examination

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify NO

(Signature) Harold B. Greenfield, M. D.
Harold B. Greenfield (Print or Type Name)
(Address) 447 Shirley St Winthrop Mass Date 4-30 1962

6 Place of Burial or Cremation: Butler Cemetery, Deering, N.H. (City or Town)

DATE OF BURIAL May 3 1962

7 NAME OF FUNERAL DIRECTOR P J Woodbury

ADDRESS Hillsboro N.H.

Received and filed APR 30 1962 19.....

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: M

9 COLOR: W

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Married.

11 If married, widowed, or divorced
HUSBAND of Margaret M. Keough (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

12 AGE 90 Years 4 Months 16 Days; If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Optometrist (Kind of work done during most working life)

14 Industry or Business: .....

15 Social Security No. no

16 BIRTHPLACE (City) Hillsboro, N.H. (State or country)

PARENTS

17 NAME OF FATHER Wm. H. Story

18 BIRTHPLACE OF FATHER (City) unknown (State or country)

19 MAIDEN NAME OF MOTHER Sarah Newell

20 BIRTHPLACE OF MOTHER (City) unknown (State or country)

21 Informant Wm. H. Story
(Address) 19 Francis St. Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Health Officer (Signature of Agent of Board of Health or other)

Health Officer (Official Designation) 4/30/62 (Date of Issue of Permit)

-62-932382

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

F1 R-301

SUCTIONS
FOR
CERTIFICATE

giving
OF DEATH

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than one
for each
b) and (c)

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of dying,
heart failure,
etc. It means
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ause last.

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dition given

15H.

Chapter 137,
1954 requires
ians to print or
e cause or
of death on
rtificates, and
48, Acts of
quires Physi-
print or type
der signature.

Directors
se only

21 1962

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT - OF - TOWN

To be filed for burial permit with Board of Health or its Agent.

Registered No. 63179

83

1 PLACE OF DEATH
SUFFOLK (County)
BOSTON (City or Town)
No. MASSACHUSETTS GENERAL HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) NO

2 FULL NAME Richmond Lingley
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. 90 Putnam Street St. Winthrop, Massachusetts
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 26 days. In place of residence 54 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March (Month) 26 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from March 1, 1962, to March 26, 1962

I last saw him alive on March 26, 1962 death is said to have occurred on the date stated above, at 7:20 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Bronchopneumonia — 10 days

Due To (b) Bleeding duodenal ulcer — 15 days

Due To (c) Adenocarcinoma of rectum — Unknown years

OTHER SIGNIFICANT CONDITIONS Arteriosclerotic cardio-vascular disease — Unknown yrs

Conditions, if any, which give rise to cause (a), stating the underlying cause last.

Other significant conditions contributing to death but not related to the terminal condition given

Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) Charles L. Clay, M. D.
Charles L. Clay, M.D.
(Print or Type Name)
(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date March 26 62

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)

DATE OF BURIAL MARCH 30 1962

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY

ADDRESS WINTHROP

Received and filed MAR 29 1962 19..
Charles H. Machse
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 CITIZEN OF U.S.	11 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN
MALE	WHITE	YES ☒ NO ☐	MARRIED ☒

11a If married, widowed, or divorced
HUSBAND of DELLA (FAY)
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 DATE OF BIRTH JUNE 12, 1880

13 AGE 81 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: STEAM FITTER
(Kind of work done during most of working life)

15 Industry or Business: HEATING & VENTILATING

16 Social Security No. 022-07-5440

17 BIRTHPLACE (City) HALIFAX
(State or country) N. S.

PARENTS

18 NAME OF FATHER THOMAS LINGLEY

19 BIRTHPLACE OF FATHER (City) HALIFAX
(State or country) N. S.

20 MAIDEN NAME OF MOTHER EMMA EASTWOOD

21 BIRTHPLACE OF MOTHER (City) HALIFAX
(State or country) N S

22 Informant MRS. DELLA LINGLEY
(Address) 90 PUTNAM ST WINTHROP.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

O. J. Ingerson jd
(Signature of Agent of Board of Health or other)

6500 — 3/28/62
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

RECEIVED

OFFICE OF TOWN CLERK
WINTHROP, MASS.

MAY 21 1962 AM

FORM R-302

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-9-59-926111

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Chelsea
(City or Town making this return)

206
Registered No. 84

1 PLACE OF DEATH
Suffolk (County)
Chelsea (City or Town)
U.S.Naval Hospital
No. ..... St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Hernandez Barrera
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so, specify WAR, ...)

(a) Residence. No. 501 Shirley St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death - years - months 2 days. In place of residence - years - months - days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 5,1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from -- 19....., to -- 19.....
I last saw h.....alive on -- 19....., death is said to have occurred on the date stated above, at -- m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Respiratory arrest	
Due To (b) Birth injury to brain	34 hrs.
Due To (c) Prematurity	34 hrs.
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? yes
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) D.W.Bailey,Lt.MC USN M. D.
(Address) USNH,Chelsea,Mass. Date 4/5/62 19.....

6 Place of Burial or Cremation Holy Cross,Malden,Mass. (City or Town)
DATE OF BURIAL April 9,1962 19.....

7 NAME OF FUNERAL DIRECTOR R.C.Kirby,Inc.
ADDRESS 917 Bennington St.,Boston,Mass.

Received and filed MAY 18 1962 19.....
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male
9 COLOR White
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Single

10a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Give name of husband in full)

Date of birth April 3,1962

11 IF STILLBORN, enter that fact here.

12 AGE - Years - Months 2 Days
If under 24 hours .....Hours.....Minutes

13 Usual Occupation: none
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) (State or country) Chelsea,Mass.

PARENTS

17 NAME OF FATHER Romeo H.Barrera

18 BIRTHPLACE OF FATHER (City) (State or country) Phillipine Islands

19 MAIDEN NAME OF MOTHER Arleen F.Hennessy

20 BIRTHPLACE OF MOTHER (City) (State or country) Everett,Mass.

21 Informant (Address) Romeo H.Barrera(father) 501 Shirley St.,Winthrop

TRUE COPY
ATTEST: Joseph A. Tyrrell
(Registrar of City or Town where death occurred)

DATE FILED April 9,1962 19.....

X

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

FORM R-301

for burial permit
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INSTRUCTIONS
FOR
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

85

(City or Town making this return)

Registered No. 038329

1 PLACE OF DEATH: Suffolk (County); Boston (City or Town)

No. New England Deaconess Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

Stewart

PHYSICIAN — IMPORTANT

2 FULL NAME Mrs. Eleanor S. Aiken (nee Patrick)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 61 Orlando Avenue St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 17 days. In place of residence 65 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April (Month) 7 (Day) 1962 (Year)

4 I HEREBY CERTIFY That I attended deceased from March 21, 1962 to April 7, 1962
I last saw her alive on April 7, 1962, death is said to have occurred on the date stated above, at 6:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Metastase

Due To (b) Carcinoma of Colon — 3 yrs

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? yes
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signature) Jurgen Fischer, M. D.
(Print or Type Name) Jurgen Fischer
(Address) N.E. Deaconess Hosp. Date 4-8 1962

6 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 11, 1962

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop,

Received and filed APR 11 1962
Charles H. Mackie
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female
9 COLOR: white
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): widowed

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Harry Wallace Aiken
(Husband's name in full)

12 AGE 85 Years 0 Months 21 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: housewife
(Kind of work done during most working life)

14 Industry or Business: own home

15 Social Security No. 010-18-8377-D

16 BIRTHPLACE (City) Cambridge
(State or country) Mass.

PARENTS

17 NAME OF FATHER William Patrick

18 BIRTHPLACE OF FATHER (City)
(State or country) Nova Scotia

19 MAIDEN NAME OF MOTHER Annie Fenerty

20 BIRTHPLACE OF MOTHER (City)
(State or country) Nova Scotia

21 Informant Harry W. Aiken
(Address) 17 Revolutionary Rd. Lex.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

6764 — 4-16-62
(Official Designation) (Date of Issue of Permit)

TRUE COPY ATTEST

NOT FOR LEGAL USE

A TRUE COPY ATTEST:

Charles A. Mackie

City Registrar

RECEIVED

TOWN CLERK WINTHROP, MASS.

MAY 21 1962 AM

R-301

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT - OF - TOWN

To be filed for burial permit with Board of Health or its Agent.

86

Registered No. 037865

PLACE OF DEATH

1 SUFFOLK (County)

BOSTON (City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Johanna Drew (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence No. 96 Nahant Avenue St. Winthrop, Massachusetts
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 9 days. In place of residence 10 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April (Month) 11 (Day) 1962 (Year)

4 I HEREBY CERTIFY. That I attended deceased from April 2, 1962, to April 11, 1962. I last saw her alive on April 11, 1962, death is said to have occurred on the date stated above, at 1:15 pm.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotis heart disease — INTERVAL BETWEEN ONSET AND DEATH: 5 mos

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS: Pneumonitis — Several days; Hiatus hernia — years

Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) C. L. Clay, M. D.
Charles L. Clay, M.D.
(Print or Type Name)
(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date April 11, 1962

6 Holy Cross Cemetery Malden
Place of Burial or Cremation (City or Town)
DATE OF BURIAL April 14, 1962

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
ADDRESS Winthrop Mass

Received and filed APR 16 1962, 19..
Charles H. Mackie (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 CITIZEN OF U.S.	11 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN
Female	White	YES X NO ☐	☐ ☐ ☐ ☐ ☐

11a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 DATE OF BIRTH

13 AGE 75 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Retired
(Kind of work done during most of working life)

15 Industry or Business: Interior Decorating

16 Social Security No. .....

17 BIRTHPLACE (City) (State or country) Newfoundland

PARENTS

18 NAME OF FATHER Lawrence Drew

19 BIRTHPLACE OF FATHER (City) (State or country) Newfoundland

20 MAIDEN NAME OF MOTHER Mary Ann Powers

21 BIRTHPLACE OF MOTHER (City) (State or country) Newfoundland

22 Informant John G. Edwards
(Address) 96 Nahant Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

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21 1962

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

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RM R-301

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JUN 8 1962

M1-61-930213

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT - OF - TOWN

To be filed for burial permit with Board of Health or its Agent. 87

Registered No. 04235

1 PLACE OF DEATH

Suffolk (County)

Boston (City or Town)

No. New England Center Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Mrs. Dorothy (First Name) Brass (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 11 Sea Foam Ave., St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months 25 days. In place of residence 40 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 24 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from March 30, 1962, to April 24, 1962

I last saw her alive on April 24, 1962, death is said to have occurred on the date stated above, at 4.45 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Congestive failure	2 days
Due To (b) sclerotic heart disease	2 years
Due To (c) Diabetes	15 years
OTHER SIGNIFICANT CONDITIONS Nephrosis	2 years

Was autopsy performed? NO
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signed) Robert H Dailey, M. D.
Robert H Dailey (Print or Type Name)
(Address) New England Center Hosp. Date 4/24 1962

6 Place of Burial or Cremation Bessarabian cemetery (City or Town) Everett
DATE OF BURIAL April 27 1962

7 NAME OF FUNERAL DIRECTOR Arnold Golov
ADDRESS 1668 Beacon St. Brookline

Received and filed APR 27 1962 1962
Charles H. Mack (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 CITIZEN OF U.S.	11 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN
Female	White	YES ☒ NO ☐	☐ ☒ ☐ ☐ ☐

11a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Harry Brass
(Husband's name in full)

12 DATE OF BIRTH

13 AGE 53 Years....Months....Days If under 24 hours ....Hours....Minutes

14 Usual Occupation: Housewife
(Kind of work done during most of working life)

15 Industry or Business: At Home

16 Social Security No. None

17 BIRTHPLACE (City) London
(State or country) England

PARENTS

18 NAME OF FATHER Joseph E. Katziff

19 BIRTHPLACE OF FATHER (City)
(State or country) Russia

20 MAIDEN NAME OF MOTHER Celia H. Meisel

21 BIRTHPLACE OF MOTHER (City)
(State or country) Russia

22 Informant Harry Brass
(Address) 11 Sea Foam Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Cecile Mastrianni
(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

HI R-301

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31-930213

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT - OF - TOWN

To be filed for burial permit with Board of Health or its Agent. 88

Registered No. 045333

PLACE OF DEATH

1 SUFFOLK (County)

BOSTON (City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL St. {(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Gertrude Cooper OK (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Residence. No. 40 Myrtle Avenue St. Winthrop, Massachusetts
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 22 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May (Month) 3 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from April 29, 1962, to May 3, 1962

I last saw he alive on May 3, 1962, death is said to have occurred on the date stated above, at 5:45p m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Pulmonary edema	1 Day
Due To (b)	Myocardial infarction	unk mos
Due To (c)	Coronary arteriosclerosis	unk mos
OTHER SIGNIFICANT CONDITIONS	Colloid Goiter	Unk yrs

Was autopsy performed? yes
What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) Chas L. Clay, M. D.
Charles L. Clay, M.D.
(Print or Type Name)
(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date May 3 1962

6 BETH ISRAEL EVERETT
Place of Burial or Cremation (City or Town)
DATE OF BURIAL 5-4 1962

7 NAME OF FUNERAL DIRECTOR TORF CHAPELS
ADDRESS CHELSEA

Received and filed MAY 8 1962 19.....
Charles H. Mackie
(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 CITIZEN OF U.S.	11 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN
FEMALE	WHITE	YES ☑ NO ☐	WIDOWED ☑

11a If married, widowed or divorced
HUSBAND of SOLOMON KUPERSLAK
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 DATE OF BIRTH 1882

13 AGE 80 Years.....Months.....Days If under 24 hours .....Hours.....Minutes

14 Usual Occupation: HOUSEWIFE
(Kind of work done during most of working life)

15 Industry or Business: OWN HOME

16 Social Security No. 014-18-7779 A

17 BIRTHPLACE (City) (State or country) RUSSIA

PARENTS

18 NAME OF FATHER HERSHEL GARBER

19 BIRTHPLACE OF FATHER (City) (State or country) RUSSIA

20 MAIDEN NAME OF MOTHER C. D. L

21 BIRTHPLACE OF MOTHER (City) (State or country) RUSSIA

22 Informant MATHEW COOPER
(Address) 40 MYRTLE AVE WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Celesta Montanino
(Signature of Agent of Board of Health or other)

7085 (Official Designation) 5-4-62 (Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

FORM R-301

d for burial permit
Board of Health
its Agent.

STRUCTIONS
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N 8. 1962

2-62-932382

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

OUT - OF - TOWN 89
(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 44517

1 PLACE OF DEATH: SUFFOLK (County); BOSTON (City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Annie Hale (Aitken)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 101 Summit Avenue St. Winthrop, Massachusetts
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 7 days. In place of residence 35 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May (Month) 3 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from April 26, 1962, to May 3, 1962, I last saw him alive on May 3, 1962 death is said to have occurred on the date stated above, at 12:20a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	INTERCEREBRAL HEMORRHAGE	1 wk
Due To (b)	HYPERTENSION	YRS
Due To (c)		
OTHER SIGNIFICANT CONDITIONS		

Was autopsy performed? yes
What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signature) C. L. Clay, M. D.
Charles L. Clay, M.D.
(Print or Type Name)
(Address) Ass't. Dir. Mass. Gen'l. Hosp. Date May 3 1962

6 Place of Burial or Cremation Winthrop (City or Town)
DATE OF BURIAL May 7 1962

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds
ADDRESS Winthrop, Mass

Received and filed MAY 8 1962
Charles H. Mackie
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Married

11 If married, widowed, or divorced
HUSBAND of .....
(or) WIFE of John H Hale (Give maiden name of wife in full) (Husband's name in full)

12 AGE 71 Years 9 Months 23 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife (Kind of work done during most working life)

14 Industry or Business: Own home

15 Social Security No. 021-16-9898

16 BIRTHPLACE (City) Sidney (State or country) Australia

PARENTS
17 NAME OF FATHER Thomas Aitken
18 BIRTHPLACE OF FATHER (City) ..... (State or country) Scotland
19 MAIDEN NAME OF MOTHER Sarah Walker
20 BIRTHPLACE OF MOTHER (City) ..... (State or country) Australia

21 Informant John H Hale
(Address) 101 Sumit Ave. Winthrop, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Celeste Mastaroni
(Signature of Agent of Board of Health or other)
7684 (Official Designation) 5-4-63 (Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

M R-301A

NSTRUCTIONS FOR ...L CERTIFICATE

... giving ... OF DEATH

... not enter ... than one ... for each ... (b) and (c)

... does not mean ... de of dying, ... heart failure, ... etc. It means ... ase, or compli- ... which caused ...

... ions, if any, ... gave rise to ... cause (a), ... the under- ... cause last.

... ditions contrib- ... death but not ... the terminal ... condition given ...

465 96

... :- Chapter 137, ... of 1954, requires ... cians to print or ... the cause or ... of death on ... certificates, and ... er 48, Acts of ... requires Physi- ... to print or type ... under signature.

M.C.

JUN 8 1962

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT - OF - TOWN

To be filed for burial permit with Board of Health or its Agent.

Registered No. 15577

1 PLACE OF DEATH
Suffolk (County)
Boston (City or Town)
No. Beth Israel Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

2 FULL NAME Joseph (First Name) Joseph P. (Middle Name) McGarry (Last Name) Mc Garry
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 283 (Usual place of abode) Main St. St. Winthrop, Mass (If nonresident, give city or town and State)

Length of stay: In place of death ... years ... months 15 days. In place of residence 30 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May (Month) 4 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from April 20, 1962 to May 4, 1962
I last saw h. alive on May 4, 1962, death is said to have occurred on the date stated above, at 2:10 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) BILATERAL PULMONARY INFARCTS — INTERVAL BETWEEN ONSET AND DEATH 2 hrs
Due To (b)
Due To (c)
OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? Yes
What test confirmed diagnosis? AUTOPSY -

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Edward J. Rolde, M. D
Edward J. Rolde (PRINT OR TYPE SIGNATURE)
(Address) 330 Brookline Ave Boston Date May 4 1962

6 Mt. Pleasant (Place of Burial or Cremation) Arlington Mass (City or Town)
DATE OF BURIAL May 7 1962

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
ADDRESS Winthrop, Mass

Received and filed MAY 8 1962 19...
Charles A. Mackie (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male
9 COLOR White
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Married

10a If married, widowed, or divorced HUSBAND of Mary J. McPhail (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 63 Years ... Months ... Days — If under 24 hours ... Hours ... Minutes

13 Usual Occupation: Clerk (Kind of work done during most of working life)

14 Industry or Business: Registry Motor Vehicles

15 Social Security No.

16 BIRTHPLACE (City) Arlington (State or country) Mass

PARENTS
17 NAME OF FATHER James McGarry
18 BIRTHPLACE OF FATHER (City) (State or country) Ireland
19 MAIDEN NAME OF MOTHER Eva Buckley
20 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

21 Informant Mary J. McGarry (Address) 283 Main St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Steven J. Stearns (Signature of Agent of Board of Health or other)
05327 (Official Designation) May 9, 1962 (Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

CM R-301

INSTRUCTIONS FOR CAL CERTIFICATE

giving OF DEATH

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:- Chapter 137, of 1954 requires cians to print or the cause or of death on certificates, and er 48, Acts of requires Physi- to print or type under signature.

M. C.

8 1962

61-930213

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT - OF - TOWN

To be filed for burial permit with Board of Health or its Agent. 91

Registered No. 46336

1 PLACE OF DEATH
SUFFOLK (County)
BOSTON (City or Town)
No. New England Center Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Walter (First Name) D (Middle Name) Ramsey (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence, No. 27 Vine Ave (Usual place of abode) St. Winthrop, Massachusetts (If nonresident, give city or town and State)

Length of stay: In place of death ... years ... months 28 days. In place of residence 50 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May (Month) 4 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from April 7 1962 to May 4 1962

I last saw him alive on May 4 1962, death is said to have occurred on the date stated above, at 6:25 pm.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Respiratory failure

Due To (b) Pulmonary Embolism ?

Due To (c)

OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH ? 72hrs

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? ...
If so, specify ...

(Signed) Alfred Tarisco, M. D.
Alfred TARISCO (Print or Type Name)
(Address) N.E.C.H. Date 5/5 1962

6 Winthrop Place of Burial or Cremation Winthrop (City or Town)

DATE OF BURIAL May 8 1962

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass

Received and filed MAY 9 1962
Charles H. Mackie (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 CITIZEN OF U.S.	11 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN
Male	White	YES ☑ NO ☐	☐ ☐ ☐ ☐ ☐

11a If married, widowed, or divorced
HUSBAND of Margaret Reid (Give maiden name of wife in full)
(or) WIFE of ... (Husband's name in full)

12 DATE OF BIRTH 11/6/85

13 AGE 76 Years 5 Months 28 Days — If under 24 hours ... Hours ... Minutes

14 Usual Occupation: Deputy Collector (Kind of work done during most of working life)

15 Industry or Business: State Income Tax

16 Social Security No. None

17 BIRTHPLACE (City) East Boston (State or country) Mass

PARENTS

18 NAME OF FATHER John Ramsey

19 BIRTHPLACE OF FATHER (City) ... (State or country) Canada

20 MAIDEN NAME OF MOTHER Jane Gregg

21 BIRTHPLACE OF MOTHER (City) ... (State or country) Canada

22 Informant Margaret R Ramsey
(Address) 27 Vine Ave. Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

John J. Ramsey Jr (Signature of Agent of Board of Health or other)

M.C. 5/7/62

(Official Designation) (Date of Issue of Permit)

T.V.V.

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

RECEIVED

JUN - 8 1962 AM

M R-301

RUCTIONS FOR CERTIFICATE

giving OF DEATH

ot enter than one for each (b) and (c)

oes not mean e of dying, heart failure, etc. It means e, or compli- which caused

ons, if any, gave rise to cause (a), the under- cause last.

itions contrib- death but not the terminal ndition given

451

85

:- Chapter 137, 1954 requires ans to print or he cause or e of death on certificates, and r 48, Acts of equires Physi- o print or type ender signature.

Director use only

K Ink.

JUL 8 1962

31-930213

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT - OF - TOWN

To be filed for burial permit with Board of Health or its Agent. 92

Registered No. 014636

PLACE OF DEATH

1 SUFFOLK (County)

BOSTON (City or Town)

No. Massachusetts General Hospital BAKER MEMORIAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME William Benker (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) WW II

(a) Residence, No. 16 Egleton Park (Usual place of abode) Winthrop, Massachusetts (If nonresident, give city or town and State)

Length of stay: In place of death ... years ... months 1 days. In place of residence 15 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May (Month) 6, (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from May 6, 1962, to May 6, 1962, I last saw him alive on May 6, 1962 death is said to have occurred on the date stated above, at 3:55P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Ruptured Aortic Aneurysm

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH: 3hrs

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? ...
If so, specify ...

(Signed) Chlay, M. D.

Charles L. Clay, M.D. (Print or Type Name)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date ... 19...

6 Winthrop Cemetery, Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 9, 1962

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 147 Winthrop St., Winthrop

Received and filed MAY 9 1962 19...

Charles H. Mackie (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 CITIZEN OF U.S.	11 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN
male	white	YES ☒ NO ☐	☐ ☒ ☐ ☐ ☐

11a If married, widowed, or divorced
HUSBAND of Rose M. Sabino (Give maiden name of wife in full)
(or) WIFE of ... (Husband's name in full)

12 DATE OF BIRTH Sept. 28, 1900

13 AGE 61 Years 7 Months 8 Days — If under 24 hours ... Hours ... Minutes

14 Usual Occupation: Testman (Kind of work done during most of working life)

15 Industry or Business: Telephone Co.

16 Social Security No. 011-05-0690

17 BIRTHPLACE (City) Boston (State or country) Mass.

PARENTS

18 NAME OF FATHER Jacob John Benker

19 BIRTHPLACE OF FATHER (City) Boston (State or country) Mass.

20 MAIDEN NAME OF MOTHER Mary E. McNamara

21 BIRTHPLACE OF MOTHER (City) Boston (State or country) Mass.

22 Informant Mrs. Rose M. Benker
(Address) 16 Egleton Pk. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

7132 (Official Designation) 5-18-62 (Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

FORM R-301

for burial permit
Board of Health
s Agent.

INSTRUCTIONS FOR CERTIFICATE

FOR TYPE OR CAUSES DEATH

ot enter than one for each (b) and (c)

oes not mean e of dying, heart failure, etc. It means e, or compli- which caused

ms, if any, ave rise to cause (a), the under- cause last.

itions contrib- death but not the terminal ndition given

Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 93

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town); No. 104 Highland Ave. St. Mount's Rest Home (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Thomas Murnane
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 104 Highland Ave. St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..years 3 months ..days. In place of residence ..years ..months ..days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May (Month) 7 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ——, 19—, to ——, 19—
I last saw h— alive on ——, 19—, death is said to have occurred on the date stated above, at 4:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Natural Causes

Due To (b) Presumably Coronary Occlusion — sudden

Due To (c) Arteriosclerotic Heart Disease — 15 yrs.

OTHER SIGNIFICANT CONDITIONS None

Was autopsy performed? No
What test confirmed diagnosis? Post-Mortem Judgement

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Arthur C. Murray M. D.
Arthur C. Murray
(Print or Type Name)
Winthrop Board of Health Date 10 May 1962

6 St. Pauls Cemetary - Arlington
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May - 11 - 1962

7 NAME OF FUNERAL DIRECTOR Arthur S. Porcella

ADDRESS 876 Winthrop Ave., Revere

Received and filed MAY 10 1962 19..
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Single

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 85 Years 11 Months 10 Days — If under 24 hours ..Hours ..Minutes

13 Usual Occupation: Retired
(Kind of work done during most working life)

14 Industry or Business:

15 Social Security No. None

16 BIRTHPLACE (City) (State or country): Ireland

PARENTS

17 NAME OF FATHER: Jeremiah Murnane

18 BIRTHPLACE OF FATHER (City) (State or country): Ireland

19 MAIDEN NAME OF MOTHER: Mary Burke

20 BIRTHPLACE OF MOTHER (City) (State or country): Ireland

21 Informant (Address): Revere Bureau of Old Age Ass. City Hall, Revere, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit) 5/11/62

2-932382

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

M R-301

TRUCTIONS FOR L CERTIFICATE

giving OF DEATH

not enter e than one e for each (b) and (c)

does not mean de of dying, heart failure, etc. It means ease, or compli- which caused

ions, if any, gave rise to cause (a), the under- cause last.

itions contrib- death but not o the terminal ondition given

:- Chapter 137, f 1954 requires cians to print or the cause or s of death on certificates, and er 48, Acts of requires Physi- to print or type under signature.

. C.

l Director

e use only

CK Ink.

8 1962

51-930213

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT - OF - TOWN

To be filed for burial permit with Board of Health or its Agent.

Registered No. 04332 94

1 PLACE OF DEATH: SUFFOLK (County); BOSTON (City or Town); No. MASSACHUSETTS GENERAL HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

2 FULL NAME Frederick Lewis (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. 64 Buchanan Street St. Winthrop, Massachusetts
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..years..months 21 days. In place of residence 13 years..months..days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 11, 1962 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from April 20, 1962, to May 11, 1962, I last saw him alive on May 11, 1962, death is said to have occurred on the date stated above, at 5:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Coronary heart disease — yrs.

Due To (b) — yrs.

Due To (c) — yrs.

OTHER SIGNIFICANT CONDITIONS: Specific aortitis — yrs.; Lobar pneumonia — few days

Was autopsy performed? no.

What test confirmed diagnosis? clinical.

5 Was disease or injury in any way related to occupation of deceased? ..
If so, specify ..

(Signed) C. L. Clay, M. D.
Charles L. Clay, M.D. (Print or Type Name)
(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date May 11 1962

6 Place of Burial or Cremation GLENWOOD EVERETT (City or Town)
DATE OF BURIAL MAY 14 1962

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY
ADDRESS WINTHROP

Received and filed MAY 15 1962 19..
Charles H. Mackie (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: MALE
9 COLOR: WHITE
10 CITIZEN OF U.S.: YES ☒ NO ☐
11 SINGLE ☐ MARRIED ☒ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐

11a If married, widowed, or divorced HUSBAND of MARY C CONWAY (Give maiden name of wife in full)
(or) WIFE of .. (Husband's name in full)

12 DATE OF BIRTH

13 AGE 84 Years..Months..Days — If under 24 hours ..Hours..Minutes

14 Usual Occupation: SHIPPER (Kind of work done during most of working life)

15 Industry or Business: WHOLESALE GROCERS

16 Social Security No. 011-03-3610

17 BIRTHPLACE (City) (State or country) NOVA SCOTIA

PARENTS

18 NAME OF FATHER JAMES LEWIS

19 BIRTHPLACE OF FATHER (City) (State or country) NOVA SCOTIA

20 MAIDEN NAME OF MOTHER (UNKNOWN)

21 BIRTHPLACE OF MOTHER (City) (State or country) NOVA SCOTIA

22 Informant MRS MARY C LEWIS
(Address) 64 BUCHANAN ST WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
F. P. Grasca H 08494 (Signature of Agent of Board of Health of other)
(Official Designation) (Date of Issue of Permit) May 13, 1962

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

R-301A

UCTIONS
FOR
CERTIFICATE

giving
OF DEATH

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etc. It means
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Chapter 137,
954, requires
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48, Acts of
uires Physi-
print or type
er signature.

-59-925686

The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 95

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. Mount's Convalescent Home Inc. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Cesare Pavone (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No. Nantasket Avenue St. Nantasket
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 4 years 6 months - days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAY (Month) 11 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec., 1955, to May 11, 1962

I last saw him alive on May 10, 1962, death is said to have occurred on the date stated above, at 1:50 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

	INTERVAL BETWEEN ONSET AND DEATH
(a) Left Hemiplegia	7yrs.
Due To (b) Hypertension	7yrs
Due To (c) Arteriosclerosis.	7yrs
OTHER SIGNIFICANT CONDITIONS Carcinoma of skin	2mos.
Bronchiectasis.	7yrs

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Charles Lieberman M. D.
CHARLES LIBERMAN
(PRINT OR TYPE SIGNATURE)

(Address) WINTHROP Date 5/11/ 1962

6 Holy Cross Cemetery Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 14, 1962

7 NAME OF FUNERAL DIRECTOR Vincent Rapino

ADDRESS 9 Chelsea St. East Boston, Mass.

Received and filed MAY 14 1962 19..
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male

9 COLOR white

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) single

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 74 Years Months Days | If under 24 hours Hours Minutes

13 Usual Occupation: Retired
(Kind of work done during most of working life)

14 Industry or Business: *****

15 Social Security No. unknown

16 BIRTHPLACE (City) (State or country) Italy

PARENTS

17 NAME OF FATHER Isadoro Pavone

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Teresa Ranieri

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant Frances Pavone (sister-in-law)
(Address) 17 Brentwood St., Malden, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Ferranni
(Signature of Agent of Board of Health or other)

Health Officer May 13, 1962
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

OM R-301

1YR 1mo.

NSTRUCTIONS FOR C CERTIFICATE

giving S OF DEATH

not enter than one for each (b) and (c)

does not mean e of dying, heart failure, etc. It means se, or compli- which caused

ons, if any, gave rise to e cause (a), the under- cause last.

itions contrib- death but not the terminal ndition given

:- Chapter 137, f 1954 requires ians to print or the cause or of death on certificates, and r 48, Acts of requires Physi- o print or type under signature.

51-930213

Countersigned by Leonard Atkins Asso. M.E.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 96

1 PLACE OF DEATH: Suffolk (County) — Chelsea 5-25-62

Winthrop (City or Town)

Mount's Convalescent Home
No. 104 Highland Avenue St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME NETTIE (First Name) McMILLAN (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence, No. 466 Broadway St. Chelsea, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May (Month) 21, (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1956 to MAY 21, 1962
I last saw her alive on MAY 21, 1962, death is said to have occurred on the date stated above, at 2.30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CONGESTIVE HEART FAILURE

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS: FRACTURED HIP treated at M.C. HOSPITAL

INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

Was autopsy performed? NO

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signed) MORRIS CLAYMAN, M. D.
198 CHESTNUT ST.
(Print or Type Name)
(Address) Chelsea Mass. Date MAY 2 1962
Morris S. Clayman, M.D.

6 Woodlawn Cemetery, Everett, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 24, 1962

7 NAME OF FUNERAL DIRECTOR John G. Welsh

ADDRESS 718 Broadway Chelsea, Mass.

Received and filed MAY 24 1962 19.....
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 CITIZEN OF U.S.	11 SINGLE ☐ MARRIED ☐ WIDOWED ☑ DIVORCED ☐ UNKNOWN ☐
Female	White	YES ☐ X NO ☐	

11a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Peter A. McMillan
(Husband's name in full)

12 DATE OF BIRTH

13 AGE 86 Years.....Months.....Days If under 24 hours .....Hours.....Minutes

14 Usual Occupation: House Work
(Kind of work done during most of working life)

15 Industry or Business: At Home

16 Social Security No. None

17 BIRTHPLACE (City) Nova Scotia
(State or country) Canada

PARENTS

18 NAME OF FATHER ? Ackles

19 BIRTHPLACE OF FATHER (City)
(State or country) Canada

20 MAIDEN NAME OF MOTHER Could not be learned

21 BIRTHPLACE OF MOTHER (City)
(State or country) Canada

22 Informant Mrs. Viva Davis (daughter)
(Address) 466 Broadway Chelsea, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

[signature]
(Signature of Agent of Board of Health or other)

Health Officer 5/22/62
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R-301A

INSTRUCTIONS FOR CERTIFICATE

giving OF DEATH

ot enter than one for each (b) and (c)

oes not mean e of dying, heart failure, etc. It means e, or compli- which caused

ions, if any, leave rise to cause (a), the under- cause last.

nditions contrib- death but not the terminal nditions given

Chapter 137, 954, requires ns to print or e cause or of death on tificates, and 48, Acts of quires Physi- print or type ler signature.

The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 97

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Winthrop Convelescent Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Mary Ellen Greer (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) NO.

(a) Residence. No. 73 Chester Avenue St. Winthrop, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ... years 2 months ... days. In place of residence 23 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAY (Month) 19 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan., 1962, to MAY 19, 1962
I last saw he alive on May 14, 1962, death is said to have occurred on the date stated above, at 7:30 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 3yrs.

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS None

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Charles Liberman M. D.
CHARLES LIBERMAN (PRINT OR TYPE SIGNATURE)
(Address) Winthrop Date 5/19/1962

6 Forest Hills Cemetery Boston
Place of Burial or Cremation (City or Town)
DATE OF BURIAL May 22, 1962

7 NAME OF FUNERAL DIRECTOR Alfred B Marsh
ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed MAY 22 1962 (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female
9 COLOR: white
10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): single

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 94 Years 8 Months 0 Days — If under 24 hours ... Hours ... Minutes

13 Usual Occupation: housework (Kind of work done during most of working life)

14 Industry or Business: own home

15 Social Security No. none

16 BIRTHPLACE (City) Lester (State or country) England

PARENTS

17 NAME OF FATHER Jonathan Hutchinson

18 BIRTHPLACE OF FATHER (City) (State or country) England

19 MAIDEN NAME OF MOTHER Ann Davis

20 BIRTHPLACE OF MOTHER (City) (State or country) England

21 Informant John Maw
(Address) 7 Walnut St. Saugus, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Ralph E. Swanson (Signature of Agent of Board of Health or other)
Health Officer (Official Designation) 5/22/62 (Date of Issue of Permit)

T V.I.V

6-59-925686

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R-301A

UCTIONS
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giving
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The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 98

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Bay View Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Agnes V Nyholm
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 42 Sargent Street St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 50 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May (Month) 19 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from August 9, 1952, to May 19, 1962
I last saw her alive on May 18, 1962, death is said to have occurred on the date stated above, at 7:45 A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Acute Myocardial Insufficiency	15 min
Due To (b) Hypertensive Heart Disease	10 yrs
Due To (c) Hypertension	10 yrs
OTHER SIGNIFICANT CONDITIONS Cerebral Hemmorrhage	3 mos.

Was autopsy performed? No
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Dorothy Cheney Appleton, M. D
DOROTHY CHENEY APPLETON
(PRINT OR TYPE SIGNATURE)
(Address) 197 Woodside Ave Winthrop, Mass Date May 20 1962

6 Winthrop (Place of Burial or Cremation) Winthrop (City or Town)
DATE OF BURIAL May 22 1962

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds
ADDRESS Winthrop, Mass

Received and filed MAY 22 1962 19
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female
9 COLOR White
10 SINGLE (write the word) MARRIED WIDOWED or DIVORCED Single

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 72 Years ..... Months ..... Days
If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: None
(Kind of work done during most of working life)

14 Industry or Business: at home

15 Social Security No. 012-21-7498

16 BIRTHPLACE (City) (State or country) Finland

PARENTS

17 NAME OF FATHER Unable to obtain Nyholm

18 BIRTHPLACE OF FATHER (City)
(State or country) Finland

19 MAIDEN NAME OF MOTHER Unable to obtain

20 BIRTHPLACE OF MOTHER (City)
(State or country) Finland

21 Informant Thomas E Key
(Address) 3 Beacon St. Boston, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
[illegible]
(Signature of Agent of Board of Health or other)
Health Officer 5/22/62
(Official Designation) (Date of Issue of Permit)

T V.B.V

928145

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

1 R-301A

RUCTIONS FOR CERTIFICATE

giving OF DEATH

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11-59-926662

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 99

PLACE OF DEATH

1 Suffolk (County)
Winthrop (City or Town)
No. 21 Nevada St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Florence E. Walker (If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 21 Nevada St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 15 years — months — days. In place of residence 15 years — months — days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May (Month) 20 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ——, 19—, to ——, 19—

I last saw h— alive on ——, 19—, death is said to have occurred on the date stated above, at 10:25 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Natural Causes	
Due To (b) Presumably Coronary Occlusion	sudden
Due To (c) Arteriosclerotic Heart Disease	years
OTHER SIGNIFICANT CONDITIONS Diabetes Mellitus	5 yrs

Was autopsy performed? NO
What test confirmed diagnosis? post-mortem judgement

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signed) Arthur C. Murray M. D.
Arthur C. Murray, M.D.
(PRINT OR TYPE SIGNATURE)
(Address) Winthrop Board of Health Date 20 May 1962

6 Liberty Progressive Everett
Place of Burial or Cremation (City or Town)
DATE OF BURIAL May 22 1962

7 NAME OF FUNERAL DIRECTOR Joy Funeral Service Inc
ADDRESS Revere

Received and filed MAY 21 1962 19—
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female
9 COLOR White
10 ~~SINGLE~~ MARRIED ~~WIDOWED~~ or ~~DIVORCED~~ (write the word) Married

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Maurice Walker (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 67 Years — Months — Days
If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: Own home

15 Social Security No. None

16 BIRTHPLACE (City) (State or country) Russia

PARENTS

17 NAME OF FATHER Benjamin Gerson

18 BIRTHPLACE OF FATHER (City) (State or country) Russia

19 MAIDEN NAME OF MOTHER Blume E. B. L. Dennberg

20 BIRTHPLACE OF MOTHER (City) (State or country) Russia

21 Informant Maurice Walker
(Address) 21 Nevada St Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Arthur C. Murray
(Signature of Agent of Board of Health or other)

Health Officer 5/21/62
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease not related to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of poisons (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 100

PLACE OF DEATH

1 SUFFOLK (County)
WINTHROP (City or Town)
No. 58 CUTLER ST. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME MARGARET A. LEMOS (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 58 CUTLER ST. St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 2 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 23 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from May 20, 1962, to May 23, 1962
I last saw her alive on May 18, 1962, death is said to have occurred on the date stated above, at 10:30 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Myocardial Heart Disease	yrs
Due To (b) Arteriosclerosis-gen.	yrs
Due To (c)	yrs
OTHER SIGNIFICANT CONDITIONS Bronchiectasis	yrs

Was autopsy performed? .....
What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....

(Signed) Joseph Gregorie, M. D.
Joseph Gregorie
(Print or Type Name)
(Address) 194 Washington Date May 23 1962

6 HOLY CROSS MALDEN
Place of Burial or Cremation (City or Town)
DATE OF BURIAL MAY 26 1962

7 NAME OF FUNERAL DIRECTOR FREDERICK J. MAGRATH
ADDRESS 325 CHELSEA ST. E. BOSTON

Received and filed MAY 24 1962 19.....
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: FEMALE
9 COLOR: WHITE
10 CITIZEN OF U.S.: YES ☑ NO ☐
11 SINGLE ☐ MARRIED ☑ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐

11a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of CLARENCE LEMOS
(Husband's name in full)

12 DATE OF BIRTH AUG. 15-1901

13 AGE 60 Years.....Months.....Days
If under 24 hours .....Hours.....Minutes

14 Usual Occupation: TELEPHONE OPERATOR
(Kind of work done during most of working life)

15 Industry or Business: RETIRED

16 Social Security No. C.N.B.L.

17 BIRTHPLACE (City) BOSTON
(State or country) MASS

PARENTS

18 NAME OF FATHER WILLIAM GARDNER

19 BIRTHPLACE OF FATHER (City) .....
(State or country) MAINE

20 MAIDEN NAME OF MOTHER MARGARET GARDENER

21 BIRTHPLACE OF MOTHER (City) BOSTON
(State or country) MASS.

22 Informant CLARENCE LEMOS
(Address) 58 CUTLER ST. WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Parker C. Sherman
(Signature of Agent of Board of Health or other)
Health Officer 5/24/62
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

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SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

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RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 101

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Winthrop Conv. Home 142 Pleasant St. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Sarah F Dunphy Nee Costello
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. (Usual place of abode) No. 212 Court Rd, St.
(If nonresident, give city or town and State)
Length of stay: In place of death 2 years months days. In place of residence 14 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 28, 1962 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from January 1959 19, to May 28, 1962, 19
I last saw her alive on May 27, 1962, 19, death is said to have occurred on the date stated above, at 9:00 am.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Arteriosclerotic heart disease	3 years
Due To (b) Generalized arteriosclerosis	5 years
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Diverticulosis of colon	

Was autopsy performed? no
What test confirmed diagnosis? X-ray and clinical findings

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) John F Collins MD M. D.
(Address) 27 Bennington Street Revere, Mass. Date May 28, 1962

6 Place of Burial or Cremation Holy Cross (City or Town) Malden
DATE OF BURIAL June 1 1962

7 NAME OF FUNERAL DIRECTOR Ernest P Caggiano
ADDRESS 147 Winthrop St, Winthrop

Received and filed MAY 29 1962 19
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female
9 COLOR White
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Widow

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of John L Dunphy (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 85 Years 7 Months 16 Days
If under 24 hours Hours Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No.

16 BIRTHPLACE (City) (State or country) Newfoundland ~~Nova Scotia~~

PARENTS

17 NAME OF FATHER Unknown

18 BIRTHPLACE OF FATHER (City) (State or country) Unknown

19 MAIDEN NAME OF MOTHER Annie Kelly

20 BIRTHPLACE OF MOTHER (City) (State or country) Unknown

21 Informant James Dunphy
(Address) 212 Court Rd, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sircaum
(Signature of Agent of Board of Health or other)

Health Officer 5/29/62
(Official Designation) (Date of Issue of Permit)

EXTRACTS

FROM THE LAWS OF THE

COMMONWEALTH OF MASSACHUSETTS

GOVERNING THE

RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . . . Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. . . — General Laws, Chap. 38, Sec. 6 , as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made.
. . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

ORM R-301

for burial permit
ard of Health
s Agent.

RUCTIONS
FOR
CERTIFICATE

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 102

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town); No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Brendan J. Keenan (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Residence. No. 87 Washington Ave (Usual place of abode) St. Winthrop Mass (If nonresident, give city or town and State)

Length of stay: In place of death ..years..months 1½ days. In place of residence 55 years..months..days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May (Month) 28 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from June 2, 1962, to May 28, 1962, I last saw him alive on May 25, 1962 death is said to have occurred on the date stated above, at 5:15 A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Cerebro Vascular accident	3 hours
Due To (b)	Arteriosclerosis	yrs
Due To (c)	Gen. sen. ity	yrs
OTHER SIGNIFICANT CONDITIONS	Myocardial heart Disease	yrs

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? N
If so, specify

(Signature) Joseph Gregorie, M. D.
Joseph GREGORIE (Print or Type Name)
(Address) 194 Washington Ave Date 5-29 1962

6 HOLY CROSS MALDEN
Place of Burial or Cremation (City or Town)
DATE OF BURIAL JUNE 1 1962

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY
ADDRESS WINTHROP

Received and filed ..... 19..

MAY 31 1962 (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: MALE
9 COLOR: WHITE
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): WIDOWED

11 If married, widowed, or divorced HUSBAND of MARY L SULLIVAN. (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

12 AGE 88 Years. Months. Days. If under 24 hours Hours. Minutes

13 Usual Occupation: BANK TREAS. (Kind of work done during most working life)

14 Industry or Business: BANK

15 Social Security No. NONE

16 BIRTHPLACE (City) EAST BOSTON (State or country) MASS

PARENTS
17 NAME OF FATHER HENRY E KEENAN
18 BIRTHPLACE OF FATHER (City) IRELAND (State or country)
19 MAIDEN NAME OF MOTHER MARY DOHERTY
20 BIRTHPLACE OF MOTHER (City) IRELAND (State or country)

21 Informant MISS LOUISE KEENAN (Address)
87 WASHINGTON AVE WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Ralph C. Freeman M.D. (Signature of Agent of Board of Health or other)
Helen Flair (Official Designation) 5 31 1962 (Date of Issue of Permit)

2-932382

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R-301A

TRUCTIONS
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CERTIFICATE

Giving
OF DEATH

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The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 103

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. 173 Pauline Street St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

2 FULL NAME Ruphie (Pendleton) Barclay
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. 173 Pauline Street St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 50 years months days. In place of residence 70 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAY 29 1962.
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from AUG 6, 1949, to MAY 29, 1962
I last saw him alive on MAY 29, 1962, death is said to have occurred on the date stated above, at 4 45 P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) CEREBRAL VASCULAR ACCT.
Due To (b) ARTERIO-SCLEROTIC HEART DIS
Due To (c) & GENERAL ARTERIO SCLEROSIS
OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH 1 HR. 5 YRS

Was autopsy performed? NO
What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signed) Myron N. King, M. D.
MYRON N. KING M.D.
(PRINT OR TYPE SIGNATURE)
(Address) 222 PLEASANT ST WINTHROP Date 5/31 1962

6 Place of Burial or Cremation Winthrop (City or Town)
DATE OF BURIAL June 1 1962

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds
ADDRESS Winthrop, Mass

Received and filed JUN 1 1962 19
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female
9 COLOR White
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Married

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Robert Barclay
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 89 Years 5 Months 1 Days
If under 24 hours Hours Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own home

15 Social Security No. None

16 BIRTHPLACE (City) Belfast
(State or country) Maine

PARENTS
17 NAME OF FATHER Nathan Pendleton
18 BIRTHPLACE OF FATHER (City) Unable to obtain
(State or country)
19 MAIDEN NAME OF MOTHER Martha Stover
20 BIRTHPLACE OF MOTHER (City) Unable to obtain
(State or country)

21 Informant Robert Barclay
(Address) 173 Pauline St Winthrop, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Ralph C. Lorenzo Jr.
(Signature of Agent of Board of Health or other)
Health Officer 6/1/62
(Official Designation) (Date of Issue of Permit)

T V.B V

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

ORM R-301

for burial permit
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RUCTIONS
FOR
CERTIFICATE

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2-932382

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Registered No. 104

PLACE OF DEATH

1 SUFFOLK (County)

Winthrop (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

Winthrop (City or Town making this return)

PHYSICIAN — IMPORTANT

2 FULL NAME LEONARD J. SAULNIER
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Residence. No. 26 SHIRLEY ST., WINTHROP St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 23 days. In place of residence 19 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAY (Month) 30 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from JAN, 1958, to MAY 30, 1962

I last saw him alive on MAY 30, 1962, death is said to have occurred on the date stated above, at 12:30 P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

	INTERVAL BETWEEN ONSET AND DEATH
(a) ACUTE PULMONARY EMBOLUS MULTIPLE	14 HRS.
Due To (b) ACUTE MYOCARDITIS	4 WKS
Due To (c) ACUTE PNEUMONITIS	5 WKS

OTHER SIGNIFICANT CONDITIONS NONE

Was autopsy performed? YES

What test confirmed diagnosis? CLINICAL + GROSS

5 Was disease or injury in any way related to occupation of deceased? No.
If so, specify

(Signature) Myron N King, M. D.

MYRON N. KING M.D
(Print or Type Name)

(Address) 222 PLEASANT ST WINTHROP MASS Date 5/30 1962

6 WINTHROP Place of Burial or Cremation WINTHROP (City or Town)

DATE OF BURIAL JUNE 2 1962

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY

ADDRESS WINTHROP

Received and filed John A. Clark 19

MAY 31 1962 (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE

9 COLOR WHITE

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word) MARRIED

11 If married, widowed, or divorced
HUSBAND of RITA M BURRIDGE
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 40 Years ..... Months ..... Days. If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: SHEET METAL
(Kind of work done during most working life)

14 Industry or Business: HEATING

15 Social Security No. 018-16-4810

16 BIRTHPLACE (City) NOVA SCOTIA
(State or country)

PARENTS

17 NAME OF FATHER ALVIN J

18 BIRTHPLACE OF FATHER (City) NOVA SCOTIA
(State or country)

19 MAIDEN NAME OF MOTHER GRACE M COMEAU

20 BIRTHPLACE OF MOTHER (City) NOVA SCOTIA
(State or country)

21 Informant RITA M SAULNIER
(Address) 26 SHIRLEY ST WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit) 5/31/62

A TRUE COPY ATTEST:

T V.K.V

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

ORM R-301

for burial permit
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NSTRUCTIONS
FOR
CERTIFICATE

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Conditions contrib-
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to the terminal
condition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 105

1 PLACE OF DEATH
SUFFOLK (County)
WINTHROP (City or Town)
No. WINTHROP COM. HOSP. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME DANIEL H MORAN
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Residence. No. 47 HILLSIDE AVE St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months 2 days. In place of residence 36 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May (Month) 31 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec. 20, 1954, to May 31, 1962.
I last saw him alive on May 31, 1962 death is said to have occurred on the date stated above, at 6:55 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Carcinoma of urinary bladder with metastasis	8 mos
Due To (b)		
Due To (c)	Severe hypertrophic arthritis	4 yrs
OTHER SIGNIFICANT CONDITIONS	Generalized arterio-sclerosis	2 yrs

Was autopsy performed? no
What test confirmed diagnosis? Clinical & lab.

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signature) M. Traunstein Jr., M. D.
M. Traunstein, Jr., M.D.
(Print or Type Name)
(Address) 73 Bartlett Rd. Date 6-1 1962

6 WINTHROP WINTHROP
Place of Burial or Cremation (City or Town)
DATE OF BURIAL JUNE 4 1962

7 NAME OF FUNERAL DIRECTOR MAURICE W. KIRBY
ADDRESS WINTHROP

Received and filed JUN 1 1962 19.....
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: MALE
9 COLOR: WHITE
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): MARRIED

11 If married, widowed, or divorced
HUSBAND of MARY E (PITTS) MORAN
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 74 Years.....Months.....Days
If under 24 hours .....Hours.....Minutes

13 Usual Occupation: RESTAURANT PROP.
(Kind of work done during most working life)

14 Industry or Business:

15 Social Security No. 032-03-3900

16 BIRTHPLACE (City) BOSTON
(State or country) MASS

PARENTS

17 NAME OF FATHER JAMES MORAN

18 BIRTHPLACE OF FATHER (City) IRELAND
(State or country)

19 MAIDEN NAME OF MOTHER MARY DRYER

20 BIRTHPLACE OF MOTHER (City) IRELAND
(State or country)

21 Informant MRS MARY E MORAN
(Address) 47 HILLSIDE AVE WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph Liriano (MD)
(Signature of Agent of Board of Health or other)
H.O.
(Official Designation)
June 6, 1962
(Date of Issue of Permit)

62-932382

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

d for burial permit
board of Health
its Agent.

STRUCTIONS
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M -62-932382

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT - OF - TOWN
(City or Town making this return)

Registered No. 106

PLACE OF DEATH
1 SUFFOLK (County)
BOSTON (City or Town)
No. MASSACHUSETTS GENERAL HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

2 FULL NAME Lillian Mc Laren
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 22 Ocean ~~Street~~ Avenue. St. Winthrop, Massachusetts
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 44 years ....months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May (Month) 21 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from May 8, 1962, to May 21, 1962
I last saw he alive on May 21, 1962, death is said to have occurred on the date stated above, at 11:00pm.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Pulmonary Emboli — Mins
Due To (b) Phlebothrombosis, Rt Leg. — 1 wk
Due To (c) Cerebellar Hemorrhage — 2 wks

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? yes
What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signature) Chas L. Cloy, M. D.
Charles L. Cloy, M. D.
(Print or Type Name)
(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date May 21, 1962

6 Place of Burial or Cremation Winthrop (City or Town) Winthrop
DATE OF BURIAL May 23, 1962

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
ADDRESS Winthrop Mass

Received and filed MAY 24 1962, 19....
Charles H. Mackie
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Seymour J. McLaren
(Husband's name in full)

12 AGE 81 Years ....Months ....Days — If under 24 hours ....Hours ....Minutes

13 Usual Occupation: Housewife
(Kind of work done during most working life)

14 Industry or Business: Own Home

15 Social Security No. .....

16 BIRTHPLACE (City) Boston (State or country) Mass

PARENTS
17 NAME OF FATHER Carl Tirrell
18 BIRTHPLACE OF FATHER (City) Cannot be learned (State or country)
19 MAIDEN NAME OF MOTHER Augusta Anderson
20 BIRTHPLACE OF MOTHER (City) Stockholm (State or country) Sweden

21 Informant Donald McLaren
(Address) Milford. N. H.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Jacqueline Lerato
(Signature of Agent of Board of Health or other)
735-5 (Official Designation) 5/22/62 (Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

FORM R-303

...for burial permit ...board of Health ...its Agent.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48. (Deceased was a U. S. War Veteran, G.L., Chap. 46, Section 10, requires physicians to insert a recital to that effect.

SOM-9-61-93134S

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

OUT - OF - TOWN

107

(City or Town making this return)

Registered No. 054396

PLACE OF DEATH

1 SUFFOLK (County)

BOSTON (City or Town)

No. EN ROUTE TO EAST BOSTON RELIEF STATION (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME ROBERT (First Name) J. (Middle Name) LAIDLEY (Last Name)
(If deceased is a married widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence, No. 50 MAIN STREET St WINTHROP, MASS.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ...years... ...months ...days. In place of residence 18 years... months ...days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH MAY (Month) 29 (Day) 1962 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

CRUSHING INJURY OF CHEST AND NECK WITH LACERATION OF NECK AND SEVERING OF TRACHEA.

5 Accident, suicide, or homicide (specify) ACCIDENT

Date and hour of injury MAY 29 19 62

IF ACCIDENTAL, was injury causally related to the death? YES

Where did Injury occur? EAST BOSTON, MASS. (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? PUBLIC HIGHWAY (Specify type of place)

Manner of Injury DRIVER OF AUTO THAT STRUCK MTA POLE (While injury occur?)

Nature of Injury CRUSHING INJURY OF CHEST AND NECK

While at work? ...Was autopsy performed? NO

6 Was disease or injury in any way related to occupation of deceased? ...

If so, specify ...

(Signed) Leonard Atkins M. D.

LEONARD ATKINS, M.D. (Print or Type Name)

(Address) 25 SHATTUCK ST. Date MAY 30 1962

7 Place of Burial, or Cremation, Winthrop Cemetery, Winthrop (City or Town)

DATE OF BURIAL June 2nd 19 62

8 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.

ADDRESS 917 Bennington St., E. Boston

Received and filed JUN 4 1962 19...

Charles H. Mackie (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male

10 COLOR White

11 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) Single

12 If married, widowed, or divorced
HUSBAND of ...
(Give maiden name of wife in full)
(or) WIFE of ...
(Husband's name in full)

13 DATE OF BIRTH Jan. 4, 1944

14 AGE 18 Years 4 Months 25 Days. If under 24 hours ...Hours ...Minutes

15 Usual Occupation Student
(Kind of work done during most of working life)

16 Industry or Business School

17 Social Security No. 030-32-9873

18 BIRTHPLACE (City) Boston (State or country) Mass.

PARENTS

19 NAME OF FATHER Frederick F. Laidley

20 BIRTHPLACE OF FATHER (City) Boston (State or country) Mass.

21 MAIDEN NAME OF MOTHER Florence Ciampa

22 BIRTHPLACE OF MOTHER (City) Boston (State or country) Mass.

23 Informant Mr. Frederick F. Laidley-father
(Address) 50 Main St., Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

William J. Lane
(Signature of Agent of Board of Health or other)

A-07473 (Official Designation) 5/31/62 (Date of Issue of Permit)

EMBALMED

138

X22

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

FRM R-301

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 108

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Margaret Grant (White)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 437 Winthrop St. Winthrop St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months 1 days. In place of residence 40 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 1 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1959, to June 1, 1962
I last saw he alive on June 1, 1962 death is said to have occurred on the date stated above, at 9:10 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Coronary Occlusion acute	2 days
Due To (b)	Hypertension	3 yrs.
Due To (c)	Arteriosclerotic Heart Disease	3 yrs

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Lieberman M. D.
CHARLES LIEBERMAN
(Print or Type Name)
(Address) WINTHROP Date 6/1/1962

6 Winthrop Place of Burial or Cremation Winthrop (City or Town)
DATE OF BURIAL June 5 1962

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds
ADDRESS Winthrop, Mass

Received and filed JUN 4 1962 19....
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Widow

11 If married, widowed, or divorced
HUSBAND of ....
(Give maiden name of wife in full)
(or) WIFE of Charles W Grant
(Husband's name in full)

12 AGE 66 Years 7 Months 20 Days
If under 24 hours ....Hours ....Minutes

13 Usual Occupation: Inspector
(Kind of work done during most working life)

14 Industry or Business: Typewriter factory

15 Social Security No. 011-01-5118

16 BIRTHPLACE (City) East Boston
(State or country) Mass

PARENTS

17 NAME OF FATHER James White

18 BIRTHPLACE OF FATHER (City)....
(State or country) Scotland

19 MAIDEN NAME OF MOTHER Jeanie Watson

20 BIRTHPLACE OF MOTHER (City)....
(State or country) Scotland

21 Informant Mary Hersey
(Address)
142 Cliff Ave. Winthrop, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

Health Officer 6/4/62
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

ORM R-301

le for burial permit
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RUCTIONS
FOR
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OF DEATH

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Registered No. 109

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town) (City or Town making this return)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

Ruth A. Harrison (Munnis)

2 FULL NAME Harrison (Munnis) Ruth
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 79 Woodside Ave. St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months 10 days. In place of residence 5 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 3 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased, from FEB 21, 1962, to JUNE 3, 1962
I last saw he alive on JUNE 3, 1962, death is said to have occurred on the date stated above, at 8:00 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) MYOCARDIAL ISCHEMIA — INTERVAL BETWEEN ONSET AND DEATH 5 MO

Due To (b) RHEUMATIC & ARTERIO SCLEROTIC HEART DIS. WITH

Due To (c) CONGESTIVE HEART FAILURE — 1 YR

OTHER SIGNIFICANT CONDITIONS None

Was autopsy performed? No
What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Myron N. King, M. D.
MYRON N. KING MD
(Print or Type Name)
(Address) 222 PLEASANT ST WINTHROP Date 6/4 1962

6 Woodlawn Everett, Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 6, 1962

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed JUN 5 1962 19....

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: Widowed

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of William A. Harrison
(Husband's name in full)

12 AGE 62 Years....Months....Days — If under 24 hours ....Hours....Minutes

13 Usual Occupation: Housewife
(Kind of work done during most working life)

14 Industry or Business: Own Home

15 Social Security No.

16 BIRTHPLACE (City) Somerville
(State or country) Mass

PARENTS

17 NAME OF FATHER John Munnis

18 BIRTHPLACE OF FATHER (City)
(State or country) Ireland

19 MAIDEN NAME OF MOTHER Sarah Martin

20 BIRTHPLACE OF MOTHER (City)
(State or country) Ireland

21 Informant Robert Harrison
(Address)
79 Woodside Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Walter E. Jenkins
(Signature of Agent of Board of Health or other)
Health Officer 6/5/62
(Official Designation) (Date of Issue of Permit)

62-932382

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R-301A

INSTRUCTIONS FOR CERTIFICATE

Filing of DEATH

Do not enter more than one cause for each (a), (b) and (c)

"Cause" does not mean mode of dying, as heart failure, asphyxia, etc. It means disease, or complication which caused death.

Conditions, if any, which have arise to the cause (a), and the underlying cause last.

Conditions contributing to death but not related to the terminal condition given

Sec.

Note: Chapter 137, Acts of 1954, requires physicians to print or type the cause of death on death certificates, and Chapter 48, Acts of requires Physicians to print or type the order signature.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 110

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. 36 Pleasant Street St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

2 FULL NAME Irene G (Strout) Perry
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. 36 Pleasant Street St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 56 years ... months ... days. In place of residence 56 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 3 (Day), 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec. 5, 1961, to June 3, 1962
I last saw her alive on June 1, 1962, death is said to have occurred on the date stated above, at 9 A. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Hypostatic Pneumonia	3 days
Due To (b)	Myocarditis	1 year
Due To (c)	Arterio-Sclerosis (6)	years
OTHER SIGNIFICANT CONDITIONS	Advanced Carcinoma of Right Breast	

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Wallace Haley, M. D.
WALLACE HALEY
(PRINT OR TYPE SIGNATURE)
(Address) 213 Pauline St Winthrop Date June 3 1962

6 Forrest Hills Cemetery Harrington, Maine
Place of Burial or Cremation (City or Town)
DATE OF BURIAL June 7 1962

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds
ADDRESS Winthrop, Mass

Received and filed JUN 4 1962 19...
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: FEMALE
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Widow

10a If married, widowed, or divorced
HUSBAND of ...
(Give maiden name of wife in full)
(or) WIFE of Newell A Perry
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 84 Years 8 Months 3 Days
If under 24 hours ... Hours ... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own home

15 Social Security No. None

16 BIRTHPLACE (City) Harrington
(State or country) Maine

PARENTS

17 NAME OF FATHER Uriah Strout

18 BIRTHPLACE OF FATHER (City) Unable to obtain
(State or country)

19 MAIDEN NAME OF MOTHER Isadora Strout

20 BIRTHPLACE OF MOTHER (City) Unable to obtain
(State or country)

21 Informant Stewart S Perry
(Address) 36 Pleasant St. Winthrop, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Walter C. Sarsanty
(Signature of Agent of Board of Health or other)
Health Officer 6/4/62
(Official Designation) (Date of Issue of Permit)

V.R.

6-1-928145

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R-301A

STRUCTIONS
OR
CERTIFICATE

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OF DEATH

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Chapter 137,
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48, Acts of
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-928145

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 111

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. 14 Pleasant Park Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Charles Emerson Seabury (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO.

(a) Residence, No. 14 Pleasant Park Road St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 40 years ..... months ..... days. In place of residence 40 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 6 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1960, to June 6, 1962
I last saw him alive on June 6, 1962, death is said to have occurred on the date stated above, at 10:45 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Arteriosclerotic & hypertensive heart disease with	2 yrs
Due To (b)	coronary sclerosis Generalized arteriosclero-	4 yrs
Due To (c)	sis	

OTHER SIGNIFICANT CONDITIONS: Chronic bronchitis

Was autopsy performed? no
What test confirmed diagnosis: Clinical & laboratory

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) M. Traunstein Jr., M. D
M. Traunstein, Jr., M.D.
(PRINT OR TYPE SIGNATURE)
(Address) 73 Bartlett Rd Date June 7, 1962

6 Winthrop Cemetery Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 9, 1962 19

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed JUN 8 1962 19
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: male
9 COLOR: white
10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): single

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 73 Years 1 Months 28 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: retired maintenance man
(Kind of work done during most of working life)

14 Industry or Business: Nickle Alloy Mfg. Co.

15 Social Security No. 012-01-1346

16 BIRTHPLACE (City) Brighton
(State or country) Massachusetts

PARENTS

17 NAME OF FATHER Charles Thomas Seabury

18 BIRTHPLACE OF FATHER (City) Parkman
(State or country) Maine

19 MAIDEN NAME OF MOTHER Martha Harvey

20 BIRTHPLACE OF MOTHER (City) Parkman
(State or country) Maine

21 Informant Ralph H. Seabury
(Address) 52 Aberdeen Rd. Arlington

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sessions
(Signature of Agent of Board of Health or other)

Health Officer 6/8/62
(Official Designation) (Date of Issue of Permit)

V.B.V

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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6928145

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 112

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. 90 Highland Ave., St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

(Was deceased a U. S. War Veteran, if so specify WAR)

2 FULL NAME Anna K. Green
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 90 Highland Ave., St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 50 years ... months ... days. In place of residence 50 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 9, 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 15 May, 1962, to 9 June, 1962

I last saw her alive on 9 June, 1962, death is said to have occurred on the date stated above, at 5:30 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Malnutrition	1 year
Due To (b)	Esophageal Obstruction	2 years
Due To (c)		
OTHER SIGNIFICANT CONDITIONS	Oral Sepsis	10 years

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Arthur C. Murray M. D

Arthur C. Murray, M.D.
(PRINT OR TYPE SIGNATURE)

(Address) Winthrop, Mass. Date 11 June 1962

6 Cambridge Cemetery Cambridge
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 12, 1962

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed JUN 11 1962 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Single

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE Years Months Days — If under 24 hours Hours Minutes

13 Usual Occupation: At Home
(Kind of work done during most of working life)

14 Industry or Business: None

15 Social Security No.

16 BIRTHPLACE (City) [illegible]
(State or country)

PARENTS

17 NAME OF FATHER Jeremiah Green

18 BIRTHPLACE OF FATHER (City)
(State or country) Ireland

19 MAIDEN NAME OF MOTHER Emeline L. Beckett

20 BIRTHPLACE OF MOTHER (City) Cambridge
(State or country) Mass

21 Informant Emmeline Green
(Address) 90 Highland Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Swanson
(Signature of Agent of Board of Health or other)

Health Officer 6/11/62
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from diseases unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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928145

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 113

X

1 PLACE OF DEATH: SUFFOLK (County) — Winthrop (City or Town)

No. WINTHROP COMMUNITY HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Clarence Northin Marsden
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) NO.

(a) Residence. No. 129 Cliff Ave., Winthrop St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months....days. In place of residence 52 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 9 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from APRIL, 1959, to JUNE 9, 1962
I last saw him alive on JUNE 9, 1962, death is said to have occurred on the date stated above, at 1.45 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	CEREBRAL HEMORRHAGE	1 DAY
Due To (b)	HYPERTENSIVE & ARTERIO-	
Due To (c)	SCLEROTIC HEART DIS.	3 YRS
OTHER SIGNIFICANT CONDITIONS	NONE	

Was autopsy performed? No
Wbat test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) Myron N. King, M. D.
MYRON N. KING
(PRINT OR TYPE SIGNATURE)
(Address) 222 PLEASANT WINTHROP Date 6/9 1962

6 Place of Burial or Cremation: Blue Hills Cemetery (City or Town) Braintree, Mass.

DATE OF BURIAL June 12, 1962 19....

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop Street, Winthrop, Mass.

Received and filed JUN 13 1962 19....
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: male
9 COLOR: white
10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): married

10a If married, widowed, or divorced HUSBAND of Elizabeth Frances Marsh
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 65 Years 2 Months 24 Days — If under 24 hours ....Hours....Minutes

13 Usual Occupation: retired traffic manager
(Kind of work done during most of working life)

14 Industry or Business: wholesale detergent Mfg.

15 Social Security No. 029-12-4995

16 BIRTHPLACE (City) Bradford
(State or country) England

PARENTS

17 NAME OF FATHER Percival William Marsden

18 BIRTHPLACE OF FATHER (City) .....
(State or country) England

19 MAIDEN NAME OF MOTHER Mary Jane Northin

20 BIRTHPLACE OF MOTHER (City) Mass.
(State or country) England

21 Informant Mrs. Clarence N. Marsden
(Address) 129 Cliff Avenue, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Ralph E. Sessions
(Signature of Agent of Board of Health or other)
Health Officer 6/11/62
(Official Designation) (Date of Issue of Permit)

V.B.V

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

ORM R-301

for burial permit
board of Health
its Agent.

INSTRUCTIONS FOR FULL CERTIFICATE

PRINT OR TYPE ITEMS OR CAUSES OF DEATH

do not enter more than one cause for each (a), (b) and (e)

does not mean side of dying, heart failure, etc. It means disease, or complication which caused death.

Conditions, if any, which gave rise to the cause (a), stating the underlying cause last.

Conditions contributing to death but not related to the terminal disease condition given in (a)

057
23

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT - OF - TOWN

(City or Town making this return)

Registered No. 5875 14

PLACE OF DEATH

SUFFOLK (County)

BOSTON (City or Town)

BOSTON CITY HOSPITAL No. ..... St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Joel Ginsberg
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Residence. No. 47 Summit Avenue St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 11, 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY, THAT I was a patient June 8, 1962, to June 11, 1962, and that death did not occur by violent or accidental means but was caused as stated below, and that death did have occurred on the date stated above, at 4:45A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute Renal Failure. — INTERVAL BETWEEN ONSET AND DEATH 3days

Due To (b) Meningococcal Meningitis with Waterhouse Friederikson Syndrome. — 3days

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed?

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Robert O'Neill Blackburn, M. D.

ROBERT O'NEILL BLACKBURN, M. D.
(Print or Type Name)

(Address) Date 6-11-62

6 LIBERTY PROGRESIVE EVERETT
Place of Burial or Cremation (City or Town)

DATE OF BURIAL 6-12 1962

7 NAME OF FUNERAL DIRECTOR J. TORF

ADDRESS CHELSEA

Received and filed JUN 12 1962 19

Charles H. Mackie
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: MALE

9 COLOR: WHITE

10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: SINGLE

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 15 Years Months Days — If under 24 hours Hours Minutes

13 Usual Occupation: STUDENT
(Kind of work done during most working life)

14 Industry or Business: AT SCHOOL

15 Social Security No. NONE

16 BIRTHPLACE (City) BOSTON
(State or country) MASS

PARENTS

17 NAME OF FATHER BENJAMIN GINSBERG

18 BIRTHPLACE OF FATHER (City) BOSTON
(State or country) MASS

19 MAIDEN NAME OF MOTHER JEANE ADELMAN

20 BIRTHPLACE OF MOTHER (City) CHICAGO
(State or country) ILLINOIS

21 Informant BENJAMIN GINSBERG
(Address) 42 SHORE DRIVE WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

J. McMahana
(Signature of Agent of Board of Health or other)

A07621 (Official Designation) 6/11/62 (Date of Issue of Permit)

62-932382

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

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N RUCTIONS FOR IC. CERTIFICATE

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cions, if any, gave rise to couse (a), the under- couse lost.

ditions contrib- death but not to the terminal condition given

1- Chapter 137, 1954, requires ans to print or he cause or of death on certificates.

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 115

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)

No. Winthrop Convalescent Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Truman G. Wolcott
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No. 10 Orlando Ave., St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 22 days. In place of residence 24 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 14 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov., 1955, to June 14, 1962
I last saw him alive on June 12, 1962, death is said to have occurred on the date stated above, at 11:30 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Reticulum Cell Carcinoma of Skin.	5 yrs
Due To (b) Carcinomatosis, due to (a)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? No
What test confirmed diagnosis? Clinical, Pathological

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Charles Liberman, M. D.
(Address) WINTHROP, MASS Date 6/14 1962

6 Place of Burial or Cremation Riverside Cemetery, Saugus (City or Town)
DATE OF BURIAL June 18, 1962

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh
ADDRESS 174 Winthrop St., Winthrop

Received and filed JUN 19 1962 19..
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male
9 COLOR white
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) married

10a If married, widowed, or divorced
HUSBAND of Lillian F. Hatch
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 77 Years ..... Months 11 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Agent
(Kind of work done during most of working life)

14 Industry or Business: Insurance

15 Social Security No. 015-20-4866

16 BIRTHPLACE (City) Winthrop
(State or country) Mass.

PARENTS

17 NAME OF FATHER Arthur Wolcott

18 BIRTHPLACE OF FATHER (City)
(State or country) Conn.

19 MAIDEN NAME OF MOTHER Julia L. Brace

20 BIRTHPLACE OF MOTHER (City)
(State or country) Conn.

21 Informant Mrs. Lillian F. Wolcott
(Address) 10 Orlando Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Ralph E. Lawrence
(Signature of Agent of Board of Health or other)
Health Officer
(Official Designation)
6/18/62
(Date of Issue of Permit)

50M-1-58-921876

EXTRACTS

FROM THE LAWS OF THE

COMMONWEALTH OF MASSACHUSETTS

GOVERNING THE

RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . .Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition, and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. . . — General Laws, Chap. 38, Sec. 6 , as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made.
. . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting [illegible] by the action of chemical (drugs or poisons) thermal, or electrical agents, to deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

FORM R-301

il: for burial permit
board of Health
its Agent.

TRUCTIONS
FOR
L CERTIFICATE

T OR TYPE
S OR CAUSES
O DEATH

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, (b) and (c)

does not mean
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heart failure,
, etc. It means
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gave rise to
cause (a),
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cause last.

Conditions contrib-
death but not
to the terminal
condition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 116

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Ida Fisher (Bix)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 325 Shirley St., Winthrop, Mass. St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 40 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JUNE (Month) 15 (Day) 1962. (Year)

4 I HEREBY CERTIFY That I attended deceased from JAN, 1955, to JUNE 15, 1962

I last saw he alive on JUNE 14, 1962, death is said to have occurred on the date stated above, at 12½ A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) MYELOGENOUS LEUKEMIA-CHR

INTERVAL BETWEEN ONSET AND DEATH 2 YRS.

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS NONE

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL + BLOOD

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Myron D. King, M. D.

MYRON D. KING, M.D.
(Print or Type Name)

(Address) 222 PLEASANT ST. WINTHROP Date 6/13/1962

6 BETH ISRAEL — EVERETT
Place of Burial or Cremation (City or Town)

DATE OF BURIAL JUNE 17 1962

7 NAME OF FUNERAL DIRECTOR MORRIS W BREZNIAK

ADDRESS 470 HARVARD ST. BROOKLINE

Received and filed JUN 15 1962 19.....

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: FEMALE

9 COLOR: WHITE

10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: MARRIED

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of IRVING FISHER
(Husband's name in full)

12 AGE 66 Years..... Months..... Days
If under 24 hours .....Hours.....Minutes

13 Usual Occupation: HOUSEWIFE
(Kind of work done during most working life)

14 Industry or Business: AT HOME

15 Social Security No.

16 BIRTHPLACE (City) (State or country) RUSSIA

PARENTS

17 NAME OF FATHER ZELICK BIX

18 BIRTHPLACE OF FATHER (City) (State or country) RUSSIA

19 MAIDEN NAME OF MOTHER MINNIE CHECKMAN

20 BIRTHPLACE OF MOTHER (City) (State or country) RUSSIA

21 Informant IRVING FISHER
(Address) 325 SHIRLEY ST. WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Lakeman
(Signature of Agent of Board of Health or other)

Health Officer 6/15/62
(Official Designation) (Date of Issue of Permit)

T V.B.

-62-932382

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

OM R-301A

STRUCTIONS FOR DIAL CERTIFICATE

In giving UE OF DEATH

not enter re than one se for each), (b) and (c)

h does not mean ode of dying, s heart failure, ea, etc. It means ease, or compli- which caused

o'itions, if any, h gave rise to be cause (a), ing the under- cause last.

nditions contrib- to death but not to the terminal condition given

:- Chapter 137, f 1954, requires ians to print or the cause or of death on certificates, and er 48, Acts of requires Physi- to print or type under signature.

M-11-59-926662

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 117

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Frederick M Williams (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 82 Hermon Street St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 7 years months days. In place of residence 50 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 24, (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from October 61, 19.., to June 24, 19 62

I last saw him alive on June 24, 19 62, death is said to have occurred on the date stated above, at 6:15 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma of the sigmoid colon with metastasis to the liver — INTERVAL BETWEEN ONSET AND DEATH: 8 mos

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS Chronic cholecystitis with cholelithiasis — 2 mos

Was autopsy performed? no

What test confirmed diagnosis? Clinical, laboratory & Surgical

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) M. Traunstein Jr. M. D.

M. Traunstein, Jr. M.D.
(PRINT OR TYPE SIGNATURE)

(Address) 73 Bartlett Rd. Date June 25, 19 62

6 Winthrop Place of Burial or Cremation Winthrop (City or Town)

DATE OF BURIAL June 27 19 62

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass

Received and filed JUN 26 1962 19..

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male

9 COLOR White

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Married

10a If married, widowed, or divorced HUSBAND of Gertrude Annis (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 74 Years 6 Months 3 Days — If under 24 hours Hours Minutes

13 Usual Occupation: Carpenter (Kind of work done during most of working life)

14 Industry or Business: Department Store

15 Social Security No. 023-09-5899

16 BIRTHPLACE (City) (State or country) England

PARENTS

17 NAME OF FATHER Samuel Williams

18 BIRTHPLACE OF FATHER (City) (State or country) England

19 MAIDEN NAME OF MOTHER Mary Herbert

20 BIRTHPLACE OF MOTHER (City) (State or country) England

21 Informant Gertrude Williams (Address) 82 Hermon St. Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph C. Lerrauno
(Signature of Agent of Board of Health or other)

Health Officer (Official Designation) 6/26/62 (Date of Issue of Permit)

V.R.V

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R[R-301A

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RUCTIONS FOR CI CERTIFICATE

] giving S] OF DEATH

lcnot enter o than one u for each a (b) and (c)

s oes not mean m'e of dying, a heart failure, u etc. It means isse, or compli- s which caused

dons, if any, c gave rise to u cause (a), i the under- g cause last.

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o :- Chapter 137, sf 1954, requires ians to print or e the cause or s of death on t certificates, and r 48, Acts of 9 requires Physi- n to print or type n under signature.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 118

1 PLACE OF DEATH

Suffolk (County)

Winthrop (City or Town)

No. ~~39 Grovers Ave.~~ Mayflower Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Mary C. Burke (First Name) Murray (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 138 Loring Road (Usual place of abode) St. (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months....days. In place of residence 30 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 28 1962 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan. 27, 1959, to June 28, 1962

I last saw her alive on June 28, 1962, death is said to have occurred on the date stated above, at 2:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Arteriosclerotic heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 year

Due To (b) Generalized arteriosclerosis — years

Due To (c)

OTHER SIGNIFICANT CONDITIONS Old Age

Was autopsy performed? no

What test confirmed diagnosis? Physical Examination.

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) John F. Collins M.D., M. D
John F. Collins, M.D.
(PRINT OR TYPE SIGNATURE)

(Address) 27 Dennington St. Revere, Mass. Date June 29, 1962

6 St. Joseph's (Place of Burial or Cremation) West Roxbury (City or Town)

DATE OF BURIAL June 30 1962

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed June 29 1962
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, or DIVORCED (write the word): Widowed

10a If married, widowed, or divorced HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Thomas F. ~~Murray~~ Burke
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 97 Years....Months....Days — If under 24 hours ....Hours....Minutes

13 Usual Occupation: At Home
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. None

16 BIRTHPLACE (City) Little Rock (State or country) Arkansas

PARENTS

17 NAME OF FATHER Bernard Murray

18 BIRTHPLACE OF FATHER (City) (State or country) Ireland

19 MAIDEN NAME OF MOTHER Mary Montgomery

20 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

21 Informant T. Murray Burke
(Address) 138 Loring Road Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Jeressen
(Signature of Agent of Board of Health or other)

Health Officer (Official Designation) 6/29/62 (Date of Issue of Permit)

60-928145

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R-301A

S UCTIONS FOR A CERTIFICATE

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ot enter than one is for each) (b) and (c)

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ns, if any, ave rise to cause (a), the under- cause last.

ions contrib- death but not the terminal ndition given

M. C.

Chapter 137, 1954, requires ns to print or e cause or of death on rtificates.

50M-1-58-921876

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 119

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)

No. Winthrop Convalescent Home St. 142 Pleasant St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary Lizzie (Ordway) Kibbey
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 260 Bowdoin St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death years 4 months 2 days. In place of residence 10 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 29 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan, 1952 to June, 1962

I last saw her alive on May 24, 1962, death is said to have occurred on the date stated above, at 3:30 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH

Due To (b) Arteriosclerotic heart disease — 10 yrs

Due To (c) senility

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis? —

5 Was disease or injury in any way related to occupation of deceased? If so, specify No

(Signed) Hos Greenfield, M. D.

(Address) 147 Shirley St. Winthrop Mass. Date June 29 1962

6 Place of Burial or Cremation Post Mills (City or Town) Thetford, Vermont

DATE OF BURIAL July 1 1962

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed JUN 29 1962 (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female

9 COLOR white

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word) widowed

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Fred Lester Kibbey
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 91 Years 6 Months 25 Days — If under 24 hours Hours Minutes

13 Usual Occupation: Housework (Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No. None

16 BIRTHPLACE (City) Santon, Minnesota (State or country)

PARENTS

17 NAME OF FATHER George Henry Ordway

18 BIRTHPLACE OF FATHER (City) Fairlee, Vermont (State or country)

19 MAIDEN NAME OF MOTHER Elizabeth Eager Crooks

20 BIRTHPLACE OF MOTHER (City) Charlestown, Mass. (State or country)

21 Informant Mrs. Philemon C. Neal
(Address) 260 Bowdoin St. Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Freeman
(Signature of Agent of Board of Health or other)

Health Officer (Official Designation) 6/29/62 (Date of Issue of Permit)

EXTRACTS

FROM THE LAWS OF THE

COMMONWEALTH OF MASSACHUSETTS

GOVERNING THE

RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . .Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. . — General Laws, Chap. 38, Sec. 6 , as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made.
. . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include deaths caused directly or indirectly by traumatism (including resulting septicemia) and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

R-301A

UCTIONS
FOR
A CERTIFICATE

giving
OF DEATH

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nder signature.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 120

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. 20 Dix Street St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

2 FULL NAME Ethel L (Adams) Smith
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 165 Woodside Ave. St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months 7 days. In place of residence 54 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 29 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ——, 19—, to ——, 19—
I last saw her alive on ——, 19—, death is said to have occurred on the date stated above, at 5:15 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Natural Causes
Due To
(b) Presumably Coronary Occlusion — 1 wk
Due To
(c) Arteriosclerotic Heart Disease — years
OTHER SIGNIFICANT CONDITIONS none

Was autopsy performed? no
What test confirmed diagnosis? post-mortem judgement

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) Arthur C. Murray, M. D
Arthur C. Murray (PRINT OR TYPE SIGNATURE)
(Address) Winthrop Board of Health Date 30 June 19 62

6 Woodlawn Crematory Everett
Place of Burial or Cremation (City or Town)
DATE OF BURIAL July 2 19 62

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds
ADDRESS Winthrop, Mass

Received and filed JUL 2 1962 19....
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female
9 COLOR White
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Widow

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Charles C Smith
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 81 Years 4 Months 23 Days — If under 24 hours ....Hours....Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own home

15 Social Security No.

16 BIRTHPLACE (City) Lowell
(State or country) Mass.

PARENTS
17 NAME OF FATHER Charles L Adams
18 BIRTHPLACE OF FATHER (City)
(State or country) Maine
19 MAIDEN NAME OF MOTHER Unable to obtain
20 BIRTHPLACE OF MOTHER (City)
(State or country) Maine

21 Informant Pauline Cook
(Address) 20 dix Street, Winthrop, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Ralph E. Ferguson
(Signature of Agent of Board of Health or other)
Health Officer 7/2/62
(Official Designation) (Date of Issue of Permit)

10-928145

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

RM R-302

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON.
THIS IS A PERMANENT RECORD

(Copies of records of deaths which occurred in your city or town in case the deceased resided in another city or town should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided at the time of death. See Sec. 12, G. L.)

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

(City or Town making this return) .....

Registered No. 121

PLACE OF DEATH

1 CHARLOTTE (County)
Punta Gorda Florida (City or Town)
No. 200 Kenyon Avenue, P. C. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME JOHN A. MOLLOY (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) W.W.I.

NON RESIDENT

CERTIFICATE OF DEATH
FLORIDA

'62-010547
STATE FILE NO.

BIRTH NO.

REGISTRAR'S NO.

This becomes a legal record when properly executed and will be placed in permanent file.

Write plainly with permanent black ink or typewriter

Funeral director must file the certificate with the local registrar within 72 hours after death or before acting any disposition of body.

4201

All items are to be complete & accurate.

V. .4012
Re .1956

1. PLACE OF DEATH a. COUNTY: Charlotte	CODE NO.: 18-027
b. CITY, TOWN, OR LOCATION: Punta Gorda, Fla.	c. IS PLACE OF DEATH INSIDE CITY LIMITS? YES [X] NO [ ]
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 200 Kenyon Ave., P.C.	e. LENGTH OF STAY IN 18: 3 Mos.
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Massachusetts	b. COUNTY:
c. CITY, TOWN, OR LOCATION: Winthrop	c. IS RESIDENCE INSIDE CITY LIMITS? YES [X] NO [ ]
d. STREET ADDRESS: RR-20 131 Bartlett Road	ON A FARM? YES [ ] NO [X]
3. NAME OF DECEASED (Type or print) First: JOHN Middle: A. Last: MOLLOY	4. DATE OF DEATH Month: March Day: 30 Year: 1962
5. SEX: Male	6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	8. DATE OF BIRTH: Sept. 4, 1896
9. AGE (In years last birthday): 65	IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Linotype Operator	10b. KIND OF BUSINESS OR INDUSTRY: Printing
11. BIRTHPLACE (State or foreign country): East Boston, Mass.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Philip Molloy	14. MOTHER'S MAIDEN NAME: Rachel B. Bradley
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W.I	16. SOCIAL SECURITY NO.: 023-14-6498
17. INFORMANT'S SIGNATURE: Florence Molloy Address: 131 Bartlett Rd. Winthrop, Mass.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: immediate

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. (Probably) ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from not to, and last saw her/him alive on 5-30-62
Death occurred at 10 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Given Thurston (Degree or title) M.D.
22b. ADDRESS 111 W. Olympia Ave Punta Gorda Fla
22c. DATE SIGNED 4-2-62

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: April 1, '62
23c. NAME OF CEMETERY OR CREMATORY: St. Joseph Cemetery
23d. LOCATION (City, town, or county): East Boston (State): Mass

24. FUNERAL DIRECTOR'S SIGNATURE: Edward R. Pongu ADDRESS: Punta Gorda, Fla.
25. DATE RECD. BY LOCAL REG.: APR 2 1962
26. REGISTRAR'S SIGNATURE: Edith Jones, Deputy

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

FORM R-301

1 for burial permit
board of Health
its Agent.

STRUCTIONS
FOR
ORIGINAL CERTIFICATE

RITE OR TYPE
USE OR CAUSES
OF DEATH

not enter
re than one
ause for each
(b) and (c)

does not mean
mode of dying,
heart failure,
etc. It means
disease, or compli-
which caused

conditions, if any,
have gove rise to
cause (a),
the under-
cause last.

Conditions contrib-
to death but not
to the terminal
condition given

9 1962

Director
use only
BLACK Ink.

-62-932382

OUT - OF - TOWN

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return) 122

Registered No. 86092

PLACE OF DEATH
1 SUFFOLK (County)
BOSTON (City or Town)
No. MASSACHUSETTS GENERAL HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) no

2 FULL NAME Bessie E. Lottman
(If deceased a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 66 Shore Drive St. Winthrop, Massachusetts
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 15 (Day) 1962 (Year)

I HEREBY CERTIFY, That I attended deceased from May 16, 1962, to June 15, 1962
I last saw her alive on June 15, 1962, death is said to have occurred on the date stated above, at 11:04am

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: UnkWks
Due To (b) Coronary Artery Occlusion — UnkYrs
Due To (c) — on
OTHER SIGNIFICANT CONDITIONS Pulmonary embolism — Unk Days

Was autopsy performed? yes
What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signature) C. L. Clay, M. D.
Charles L. Clay, M.D.
(Print or Type Name)
(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date June 15 62

6 David Vicur Choulim (Lebanon) W. Roxbury
Place of Burial or Cremation (City or Town)
DATE OF BURIAL June 17, 1962

7 NAME OF FUNERAL DIRECTOR Benjamin F. Solomon
ADDRESS 420 Harvard Street, Brookline.

Received and filed JUN 20 1962 19....
Charles H. Mackie
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female
9 COLOR: white
10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word): divorced

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Frank Lottman
(Husband's name in full)

12 AGE 81 Years.....Months.....Days — If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Button Maker (retired)
(Kind of work done during most working life)

14 Industry or Business: Factory

15 Social Security No. 014-20-4767

16 BIRTHPLACE (City) .....
(State or country) Russia

PARENTS
17 NAME OF FATHER Jacob Bortnick
18 BIRTHPLACE OF FATHER (City) .....
(State or country) Russia
19 MAIDEN NAME OF MOTHER Anna Cohen
20 BIRTHPLACE OF MOTHER (City) .....
(State or country) Russia

21 Informant (Address) Mrs. Lillian (Sidney) Balkan
20 Taylor Street, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Signature A 09258
(Signature of Agent of Board of Health or other)
(Official Designation) (Date of Issue of Permit) June 16 1962

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

M R-302

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-8-56-918227

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Saugus (City or Town making this return)

Registered No. 130

1 PLACE OF DEATH: Essex (County); Saugus (City or Town)

No. Saugus General Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Marie G McMath (Mann) (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No. 68 Crystal Cove Ave Winthrop St. Mass (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months 18 days. In place of residence 20 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 24, 1962 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 6-6-, 1962, to 6-24-, 1962. I last saw he alive on June 24, 1962, death is said to have occurred on the date stated above, at 3 A. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

	INTERVAL BETWEEN ONSET AND DEATH
(a) Pneumonia	
Due To (b) Carcinoma of gall bladder	6 mo
Due To (c) and metastases to liver	
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? no
What test confirmed diagnosis? Laboratory

5 Was disease or injury in any way related to occupation of deceased? ....
If so, specify ....

(Signed) Charles Costas M D, M. D.

(Address) no address Date no date 19....

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 27, 1962

7 NAME OF FUNERAL DIRECTOR Maurice W Kirby

ADDRESS Winthrop Mass

Received and filed JUL 16 1962 19....

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Widowe

10a If married, widowed, or divorced HUSBAND of ....
(Give maiden name of wife in full)
(or) WIFE of John A McMath
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 70 Years....Months....Days. If under 24 hours ....Hours....Minutes

13 Usual Occupation: Clerk (Kind of work done during most of working life)

14 Industry or Business: State Ins Dept

15 Social Security No. none

16 BIRTHPLACE (City) Boston (State or country) Mass

PARENTS

17 NAME OF FATHER Joseph E Mann

18 BIRTHPLACE OF FATHER (City) Unknown (State or country)

19 MAIDEN NAME OF MOTHER Alice McDonald

20 BIRTHPLACE OF MOTHER (City) .... (State or country) Unknown

21 Informant Robert McMath
(Address) 2 Dana R W Peabody

A TRUE COPY ATTEST: John T. Raicke
(Registrar of City or Town where death occurred)

DATE FILED 6-27-62 19....

T V.B.

ORM R-301

for burial permit
ard of Health
ts Agent

RUCTIONS
FOR
CERTIFICATE

OR TYPE
SIOR CAUSES
DEATH

not enter
than one
for each
(b) and (c)

does not mean
ate of dying,
heart failure,
etc. It means
ise, or compli-
which caused

sions, if any,
gave rise to
cause (a),
the under-
cause last.

ditions contrib-
death but not
to the terminal
condition given

X OUT - OF - TOWN

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return) 126

Registered No. 5 11

PLACE OF DEATH
1 County: SUFFOLK
City or Town: Boston
No. Boston Lying-in Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: BABY BOY DeMio
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence No. 21 Wadsworth Ave St. Winthrop MASS
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: JUNE (Month) 26, (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 6-24, 1962, to JUNE 26, 1962
I last saw him alive on JUNE 26, 1962 death is said to have occurred on the date stated above, at 12:30 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pulmonary Hemorrhage

Due To (b) Immaturity

Due To (c)

OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? yes
What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify

(Signature) James E. Drabaugh, M. D.
James E. Drabaugh
(Print or Type Name)
(Address) 221 Longwood Ave Date 6-26-62, 19

6 Place of Burial or Cremation: ST. MICHAEL - BOSTON (City or Town)
DATE OF BURIAL: JUNE 30, 1962

7 NAME OF FUNERAL DIRECTOR: ANDREWS & REED, INC.
ADDRESS: 231 BELMONT, ST. BELMONT

Received and filed JUL 3 1962, 19
Charles F. Macke
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: MALE
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Single

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 AGE. Years Months 1 Days | If under 24 hours: 18 Hours 18 Minutes

13 Usual Occupation
(Kind of work done during most working life)

14 Industry or Business

15 Social Security No.

16 BIRTHPLACE (City) (State or country): Boston MASS

PARENTS
17 NAME OF FATHER: Gerald A. DeMio
18 BIRTHPLACE OF FATHER (City) (State or country): Chicago Illinois
19 MAIDEN NAME OF MOTHER: Carol Stavrejes
20 BIRTHPLACE OF MOTHER (City) (State or country): Winthrop MASS

21 Informant (Address): Boston Lying-in Hospital 221 Longwood Ave, Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
(Signature of Agent of Board of Health or other)
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

7 9 1962

52-932382

A TRUE COPY ATTEST;

Charles H. Mackie

City Registrar

RECEIVED

AUG 9 1962 AM

M R-301

RUCTIONS FOR G. CERTIFICATE

giving S OF DEATH

not enter than one e for each (b) and (c)

does not mean ode of dying, heart failure, etc. It means ease, or compli- which caused

ions, if any, gave rise to cause (a), the under- cause last.

ditions contrib- death but not the terminal condition given

Chapter 137 of 1954 requires ycians to print or the cause or s of death on certificates, and er 48, Acts of 51 requires Physi- to print or type under signature.

JUN 9 1962

1 61-930213

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 125

X OUT - OF - TOWN

1 PLACE OF DEATH: Suffolk (County) — Boston (City or Town)

No. Veterans Administration Hospital xx (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME James (First Name) H (Middle Name) HOLLAND (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) WW 2

(a) Residence. No. 1 Sargent Terrace (Usual place of abode) xx Winthrop, Mass. (If nonresident, give city or town and State)

Length of stay: In place of death Dead on arrival years months days. In place of residence Life months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 26 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...

I last saw him alive on ..., 19..., death is said to have occurred on the date stated above, at 8:30 A.m.

INTERVAL BETWEEN ONSET AND DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) CORONARY THROMBOSIS

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) John P. Treanor Jr., M. D.
JOHN P. TREANOR JR MD (Print or Type Name)

(Address) Boston Health Dept. Date June 26 1962

6 Winthrop Cemetery Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL 6-29-62 19...

7 NAME OF FUNERAL DIRECTOR O'Maley F.H.

ADDRESS 79 Atlantic St., Winthrop, Mass.

Recorded and filed JUN 29 1962 19...

Charles H. Mackie (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 CITIZEN OF U.S.: YES xx NO

11 SINGLE ☐ MARRIED ☒ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐

11a If married, widowed, or divorced HUSBAND of Jane Barry (Give maiden name of wife in full)

(or) WIFE of ... (Husband's name in full)

12 DATE OF BIRTH 7-22-97

13 AGE 64 Years 11 Months 4 Days — If under 24 hours ... Hours ... Minutes

14 Usual Occupation: Master (Kind of work done during most of working life)

15 Industry or Business: Boston School Dept.

16 Social Security No. None

17 BIRTHPLACE (City) (State or country) Boston, Massachusetts

PARENTS

18 NAME OF FATHER James Holland

19 BIRTHPLACE OF FATHER (City) (State or country) Ireland

20 MAIDEN NAME OF MOTHER -------- Cont.

21 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

22 Informant (Address) V.A. Hospital Records, 150 South Huntington Ave., Boston, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

R.K.Gorman (Signature of Agent of Board of Health or other)

A07838 (Official Designation) 6-27-62 (Date of Issue of Permit)

A TRUE COPY ATTEST:

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

RECEIVED

OFFICE OF TOWN CLERK WINTHROP, MASS.

AUG 9 1962 AM

DRM R-301

for burial permit
ard of Health
ts Agent.

STRUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

ot enter
than one
for each
(b) and (c)

oes not mean
e of dying,
heart failure,
etc. It means
ie, or compli-
which caused

ions, if any,
gave rise to
cause (a),
the under-
cause last.

itions contrib-
death but not
the terminal
ndition given

C.

2-932382

X

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 126

1 PLACE OF DEATH: SUFFOLK (County); WINTHROP (City or Town)

No. WINTHROP COMMUNITY HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME FRANK P. CARUCCIO (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT: (Was deceased a U. S. War Veteran, if so specify WAR) NO

VOTING 12K74

(a) Residence. No. 76 INGLESIDE AVENUE St. WINTHROP
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 20 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 3, 1962 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 3, 1962, to July 3, 1962

I last saw him alive on July 3, 1962 death is said to have occurred on the date stated above, at 5:25 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Coronary occlusion

Due (b) Coronary artery disease

Due To (c)

OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH: 1 hour years

Was autopsy performed? No

What test confirmed diagnosis? EKG

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Joseph Gregorie, M. D.

Joseph Gregorie, M.D.
(Print or Type Name)

(Address) Winthrop, Mass. Date July 3, 1962

6 Winthrop Cemetery, Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 6, 1962

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 147 Winthrop St., Winthrop

Received and filed JUL 5 1962 19.....

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: M

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Married

11 If married, widowed, or divorced
HUSBAND of Angelina Capaldo
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 69 Years 8 Months 20 Days — If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Presser
(Kind of work done during most working life)

14 Industry or Business: Clothing

15 Social Security No. 011-01-1253

16 BIRTHPLACE (City) (State or country) Italy

PARENTS

17 NAME OF FATHER Michael Caruccio

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Angela DiCreto

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant Mrs. Angelina Caruccio
(Address) 76 Ingleside Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit) 7/5/62

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

ORM R-301

for burial permit
board of Health
its Agent.

INSTRUCTIONS FOR CERTIFICATE

giving
S OF DEATH

do not enter
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(a) (b) and (c)

does not mean
ode of dying,
heart failure,
etc. It means
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cause (a),
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cause lost.

Conditions contrib-
death but not
to the terminal
condition given

Note:- Chapter 137,
of 1954 requires
ician to print or
the cause or
s of death on
certificates, and
ter 48, Acts of
requires Physi-
to print or type
under signature.

9 1962

11-61-931825

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

X OUT - OF - TOWN

(City or Town making this return) 137

Registered No. 1 [illegible]

1 PLACE OF DEATH: SUFFOLK (County) — BOSTON MASS (City or Town)

No. ST MARGARET, S HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME BABY GIRL QUIST
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR,)

(a) Residence. No. 18 CLIFF AVE WINTHROP MASS St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years ....months ....days. In place of residence ....years ....months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 7 (Month) 4 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 7-2, 1962, to 7-4, 1962
I last saw him alive on 7-4, 1962 death is said to have occurred on the date stated above, at 8;40PM

DEATH WAS CAUSED BY IMMEDIATE CAUSE

(a) RESPIRATORY FAILURE
Respiratory Failure

Due To (b) FULUMNORY HYALINE MEMBRANE SYNDROME
Fulmonary Hyaline Membrane Syndrome

Due To (c) C/S
Caesarean Section

OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH: 2DAYS 10HRS

Was autopsy performed? NO
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupaton of deceased? No
If so, specify

(Signed) V. P. Gilliam M.D. (Print or Type Name), M. D.

(Address) St Margaret's Hosp Date 7/5 1962

6 Place of Burial or Cremation Winthrop Cemetery - Winthrop, Mass. (City or Town)

DATE OF BURIAL JULY 5 1962

7 NAME OF FUNERAL DIRECTOR FRANCIS E. KENNEY & SONS

ADDRESS 144 S RIVER ST. HYDE PARK MASS

Received and filed JUL 11 1962 19..

Charles H. Mackie
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: FEMALE

9 COLOR: WHITE

10 SINGLE (write the word) SINGLE
MARRIED
WIDOWED
DIVORCED
UNKNOWN

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE Years Months 2 Days If under 24 hours Hours Minutes

13 Usual Occupation NONE
(Kind of work done during most working life)

14 Industry or Business NONE

15 Social Security No. NONE

16 BIRTHPLACE (City) Boston, Mass.
(State or country)

PARENTS

17 NAME OF FATHER KENNETH C. QUIST

18 BIRTHPLACE OF FATHER (City) DEDHAM MASS
(State or country)

19 MAIDEN NAME OF MOTHER JEANNE E. BARRIEAU

20 BIRTHPLACE OF MOTHER (City) CHELSEA, MASS
(State or country)

21 Informant (Address) MR. KENNETH QUIST 18 CLIFF AVE WINTHROP MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

R. K. Gorman
(Signature of Agent of Board of Health or other)

A07955 (Official Designation) 7-5-62 (Date of Issue of Permit)

A TRUE COPY ATTEST:

X

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

RECEIVED

AUG 9 1962 AM

DRM R-301

or burial permit
ard of Health
s Agent.

RUCTIONS
FOR
CERTIFICATE

N OR TYPE
OR CAUSES
DEATH

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 128

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. 26 Bates Avenue, Winthrop St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Abraham Yorks
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence, No. 26 Bates Ave. St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 10 years ..... months ..... days. In place of residence 10 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JULY (Month) 10 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 7/7, 1962, to 7/10, 1962

I last saw him alive on 7/9, 1962, death is said to have occurred on the date stated above, at 8:20 A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) ARTERIO-SCLEROTIC & HYPERTENSIVE CARDIO VASCULAR DISEASE	2 YRS
Due To (b) CHRONIC GLOMERULO NEPHRITIS	5 YRS
Due To (c)	
OTHER SIGNIFICANT CONDITIONS HYPOCHROMIC SECONDARY ANEMIA CIRRHOSIS OF LIVER	2 YRS

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased No
If so, specify

(Signature) Myron N. King, M. D.
MYRON N. KING M.D.
(Print or Type Name)

(Address) 222 PLEASANT ST WINTHROP MASS Date 7/10 1962

6 Ohel Jacob Cemetery - Woburn
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 11 1962

7 NAME OF FUNERAL DIRECTOR Arnold Golov

ADDRESS 1668 Beacon St. Brookline

Received and filed July 11, 1962

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced
HUSBAND of Rose Kapulsky
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 86 Years ..... Months ..... Days. If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Master Plumber
(Kind of work done during most working life)

14 Industry or Business: Self Employed

15 Social Security No. 021-28-3191

16 BIRTHPLACE (City) Russia
(State or country)

PARENTS

17 NAME OF FATHER Yachin Yorks

18 BIRTHPLACE OF FATHER (City) Russia
(State or country)

19 MAIDEN NAME OF MOTHER Sarah (unknown)

20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)

21 Informant (Address) Ida Katz - 26 Bates Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sirrianni
(Signature of Agent of Board of Health or other)

Health Officer (Official Designation) 7/11/62 (Date of Issue of Permit)

62-932382

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

ORM R-302

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Braintree (City or Town making this return)

Registered No. 129

1 PLACE OF DEATH: Norfolk (County); Braintree (City or Town)

No. John Scott Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Lillian Frances (Hatch) Walcott (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR, No)

(a) Residence. No. 10 Orlando Avenue St. Winthrop (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 14 days. In place of residence 10 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 7 (Month) 11 (Day) 62 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 6-28, 1962 to 7/11, 1962. I last saw he alive on 7/5, 1962. Death is said to have occurred on the date stated above, at 10 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Massive Myocardial Infarction

Due To (b) Arteriosclerotic Heart Disease

Due To (c)

OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH: Minutes / Years

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Vincent Pattavina, M. D.

(Address) Professional Center So. Braintree, Mass. Date 7/12 1962

6 Place of Burial or Cremation: Riverside Cemetery (City or Town) Sagus

DATE OF BURIAL July 14, 1962

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St., Winthrop

Received and filed JUL 16 1962

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of Truman G. Walcott (Husband's name in full)

12 AGE 84 Years 8 Months 4 Days. If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: At Home (Kind of work done during most working life)

14 Industry or Business: At Home

15 Social Security No. 015-20-4866

16 BIRTHPLACE (City) Chelsea (State or country) Mass.

PARENTS

17 NAME OF FATHER Alton J. Hatch

18 BIRTHPLACE OF FATHER (City) Chelsea (State or country) Mass.

19 MAIDEN NAME OF MOTHER Annie E. Williams

20 BIRTHPLACE OF MOTHER (City) Chelsea (State or country) Mass.

21 Informant Mr. Walter H. Packard (Address) 49 Packard Drive, Braintree

A TRUE COPY Carl R. Johnson Jr.

ATTEST: (Registrar of City or Town where death occurred)

DATE FILED JUL 12 1962

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

DM R-303

for burial permit
Board of Health
ts Agent.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-9-61-931348

X

PLACE OF DEATH

1 SUFFOLK (County)
Winthrop
~~BOSTON~~ (City or Town)

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 130

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME FLORENCE PRATT [Lucas]
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 31 Villa Avenue, Winthrop St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months 14 days. In place of residence 46 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 13, 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Cerebro-vascular accident following fracture of femur.

5 Accident, suicide, or homicide (specify) Accident.
Date and hour of injury 6/27 19 62
IF ACCIDENTAL, was injury causally related to the death? Yes.
Where did Injury occur? Winthrop, Mass. (City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? Home. (Specify type of place)
Manner of Injury Fall to floor. (How did injury occur?)
Nature of Injury Fracture of femur.
While at work? ..... Was autopsy performed? No.

6 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) Michael A. Luongo, M. D.
Michael A. Luongo, M.D. (Print or Type Name)
(Address) Boston Date 7/13 19 62

7 Mt Auburn Cemb Mass
Place of Burial, or Cremation. (City or Town)
DATE OF BURIAL July 16 19 62

8 NAME OF FUNERAL DIRECTOR Ernest P Caggiano
ADDRESS 147 Winthrop St Winthrop

Received and filed JUL 16 1962 19.....
(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

9 SEX ~~Male~~ Female

10 COLOR White

11 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) Widowed

12 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of James S Pratt
(Husband's name in full)

13 DATE OF BIRTH May 20, 1877

14 AGE 85 Years 1 Months ..... Days. If under 24 hours .....Hours .....Minutes

15 Usual Occupation Housewife
(Kind of work done during most of working life)

16 Industry or Business at Home

17 Social Security No. .....

18 BIRTHPLACE (City) (State or country) Plymouth Mass

PARENTS

19 NAME OF FATHER Unknown Lucas

20 BIRTHPLACE OF FATHER (City) (State or country) ?

21 MAIDEN NAME OF MOTHER Unknown

22 BIRTHPLACE OF MOTHER (City) (State or country) ?

23 Informant William B Pratt
(Address) 31 Villa Ave Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Walter E. Sweeney
(Signature of Agent of Board of Health or other)
Health Officer 7/16/62
(Official Designation) (Date of Issue of Permit)

MEDICAL

m.c.

T V.B.

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

110

R-301

STRUCTIONS
OR
AL CERTIFICATE

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rtificates, and
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quires Physi-
print or type
der signature.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 131

1 PLACE OF DEATH
County: Suffolk
City or Town: Winthrop
No. 78 Cottage Ave St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME William G. Greenfield (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) WW 2

(a) Residence, No. 78 Cottage Ave St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months....days. In place of residence 1 years 6 months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July (Month) 17, (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...

I last saw him alive on ....., 19..., death is said to have occurred on the date stated above, at 7 P.M.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Sudden Death - Probably coronary heart disease.

Due To (b) Pre-existing coronary heart disease

Due To (c) (Treated at M.G.H. 1961, 1962 (1½ years)

INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS none

Was autopsy performed? no

What test confirmed diagnosis? Previous hospital admissions.

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) John F. Collins M. D.
John F. Collins (Print or Type Name)
(Address) 27 Bennington St. Beachmont, Mass. (July 18, 1962)
for Winthrop Board of Health, Winthrop, Mass.

6 Place of Burial or Cremation Holy Cross (City or Town) Malden

DATE OF BURIAL July 20 1962

7 NAME OF FUNERAL DIRECTOR Frederick J. MAGRATH

ADDRESS 325 Chelsea St. E. Boston

Received and filed JUL 19 1962 19.....
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 CITIZEN OF U.S.	11
Male	White	YES ☑ NO ☐	SINGLE ☑ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐

11a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 DATE OF BIRTH Nov. 29, 1913

13 AGE 48 Years 7 Months ....Days | If under 24 hours ....Hours....Minutes

14 Usual Occupation: Steamship Clerk
(Kind of work done during most of working life)

15 Industry or Business: Local 1066 I.L.A.

16 Social Security No. 025-03-7712

17 BIRTHPLACE (City) East Boston
(State or country) MASS.

PARENTS

18 NAME OF FATHER Charles Greenfield

19 BIRTHPLACE OF FATHER (City) Boston
(State or country) MASS.

20 MAIDEN NAME OF MOTHER Mary Angel

21 BIRTHPLACE OF MOTHER (City) .....
(State or country) Newfoundland

22 Informant Thomas Greenfield
(Address) 70 Cottage Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Williams
(Signature of Agent of Board of Health or other)

Health Officer (Official Designation) 7/19/62 (Date of Issue of Permit)

A TRUE COPY ATTEST:

-930213

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE 2-15-42

DATE OF DISCHARGE 11-4-45

RANK, RATING ..... Corp.

ORGANIZATION AND OUTFIT ..... Hqtrs. Sqdn. 11th Air Dep. Grp. U.S. A

SERVICE NUMBER 31 064 626

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

For burial permit
Board of Health
Agent.

INSTRUCTIONS
FOR
CERTIFICATE

FOR TYPE
OR CAUSES
DEATH

Not enter
than one
for each
b) and (c)

es not mean
of dying,
heart failure,
etc. It means
ee, or compli-
which caused

ns, if any,
ave rise to
cause (a),
the under-
cause last.

tions contrib-
death but not
the terminal
ndition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 132

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Jennie E. Resnick
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Residence. No. 147 Shirley St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months 28 days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July (Month) 17 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 11, 1962, to July 17, 1962
I last saw her alive on July 16, 1962 death is said to have occurred on the date stated above, at 4:15 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma of lungs

Due To
(b)

Due To
(c)

OTHER SIGNIFICANT CONDITIONS Diabetes Melitus

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? No
What test confirmed diagnosis? X-rays

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) John F. Collins M.D., M. D.
John F. Collins, M. D.
(Print or Type Name)
(Address) 27 Pennington St. Date July 17 1962
Revere, Mass.

6 Place of Burial or Cremation AMERICAN FRIENDSHIP W. ROXBURY (City or Town)
DATE OF BURIAL July 18 1962

7 NAME OF FUNERAL DIRECTOR TORF FUNERAL SERVICE
ADDRESS CHELSEA

Received and filed July 18, 1962
John A. Clark
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE
9 COLOR WHITE
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word) MARRIED

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of ISADORE RESNICK
(Husband's name in full)

12 AGE 65 Years.....Months.....Days
If under 24 hours .....Hours.....Minutes

13 Usual Occupation: HOUSE WIFE
(Kind of work done during most working life)

14 Industry or Business: OWN HOME

15 Social Security No.

16 BIRTHPLACE (City) (State or country) RUSSIA

PARENTS

17 NAME OF FATHER MORRIS WISEMAN

18 BIRTHPLACE OF FATHER (City) (State or country) RUSSIA

19 MAIDEN NAME OF MOTHER CLARA ORNSTEIN

20 BIRTHPLACE OF MOTHER (City) (State or country) RUSSIA

21 Informant MAURICE RESNICK
(Address) 112 IRVING ST. EVERETT

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Robert E. Sullivan
(Signature of Agent of Board of Health or other)
Registrar
(Official Designation) (Date of Issue of Permit)

2-932382

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

DM R-303

e or burial permit
Board of Health
rs Agent.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-9-61-931348

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

PLACE OF DEATH

1 SUFFOLK (County)
WINTHROP (City or Town)

(City or Town making this return)

Registered No. 133

No. Waters of Boston Harbor off Winthrop St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME DANIEL J HERBERT Jr
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence, No. 244 Grand View Avenue, Winthrop St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 2 years 7 months 13 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July (Month) 18, (Day) 1962 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Asphyxia due to drowning,

5 Accident, suicide, or homicide (specify) Accident.
Date and hour of injury July 18, 19 62
IF ACCIDENTAL, was injury causally related to the death? Yes
Where did Injury occur? Winthrop, Massachusetts.
(City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? Waters of Boston Harbor.
(Specify type of place)
Manner of Injury Accidental fall, wall into soa water
(How did injury occur?)
Nature of Injury
While at work? ..... Was autopsy performed? Yes

6 Was disease or injury in any way related to occupation of deceased?
If so, state

(Signed) Michael A. Luongo, M. D.
Michael A. Luongo, M.D.
(Print or Type Name)
(Address) Boston Date 7/18 19 62

7 Winthrop Cemetery Winthrop
Place of Burial, or Cremation. (City or Town)
DATE OF BURIAL July 20, 19 62

8 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
ADDRESS Winthrop Mass

Received and filed 7-20 19 62
(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male
10 COLOR White
11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Single

12 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

13 DATE OF BIRTH January 5, 1960

14 AGE 2 Years 7 Months 13 Days If under 24 hours ....Hours ....Minutes

15 Usual Occupation
(Kind of work done during most of working life)

16 Industry or Business

17 Social Security No.

18 BIRTHPLACE (City) Winthrop
(State or country) Mass

PARENTS

19 NAME OF FATHER Daniel J. Herbert

20 BIRTHPLACE OF FATHER (City) Boston
(State or country) Mass

21 MAIDEN NAME OF MOTHER Margaret Jones

22 BIRTHPLACE OF MOTHER (City) Winthrop
(State or country) Mass

23 Informant Margaret Herbert
(Address) 244 Grand View Ave Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
(Signature of Agent of Board of Health or other)
Health Officer 7/19/62
(Official Designation) (Date of Issue of Permit)

MEDICAL

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

R-301A

INSTRUCTIONS FOR CERTIFICATE OF DEATH

giving ... not enter than one for each (b) and (c)

...es nat mean ...e of dying, heart failure, etc. It means ...se, or compli- which caused

...ons, if any, gave rise to cause (a), the under- cause last.

...itions contrib- death but not the terminal condition given

...n C.

Chapter 137, 954, requires ...ns to print or ...e cause or ...of death on ...rtificates, and ...48, Acts of ...quires Physi- print or type ...ler signature.

11-59-926662

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 134

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. 77 Bartlett Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Frank E Johnson (Was deceased a U. S. War Veteran, if so specify WAR) W.W.1
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 77 Bartlett Road St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 13 years ... months ... days. In place of residence 13 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July (Month) 18 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from June, 1950, to July 18, 1962

I last saw h. alive on July 17, 1962 death is said to have occurred on the date stated above, at 11:10 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: yrs

Due To (b) Coronary artery disease — yrs

Due To (c) Arteriosclerosis - gen — yrs

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Joseph Gregoire, M. D.
Joseph Gregoire
(PRINT OR TYPE SIGNATURE)
(Address) 194 Washington Date 7/19 1962

6 Forrest Dale Malden
Place of Burial or Cremation (City or Town)
DATE OF BURIAL July 22 1962

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds
ADDRESS Winthrop Mass

Received and filed JUL 20 1962 19...
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male

9 COLOR White

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Married

10a If married, widowed, or divorced HUSBAND of Ruth Baker
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 63 Years 8 Months 8 Days — If under 24 hours ... Hours ... Minutes

13 Usual Occupation: Clerk
(Kind of work done during most of working life)

14 Industry or Business: Federal Reserve Bank

15 Social Security No. 025-26-4198

16 BIRTHPLACE (City) Bristol
(State or country) Rhode Island

PARENTS

17 NAME OF FATHER George Johnson

18 BIRTHPLACE OF FATHER (City)
(State or country) England

19 MAIDEN NAME OF MOTHER Clara Bradshaw

20 BIRTHPLACE OF MOTHER (City) Bristol
(State or country) Rhode Island

21 Informant Ruth Johnson
(Address) 77 Bartlett Rd. Winthrop, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sirianni
(Signature of Agent of Board of Health or other)

Health Officer — July 20/62
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE October 30, 1918

DATE OF DISCHARGE December 5, 1918

RANK, RATING Private

ORGANIZATION AND OUTFIT Army

SERVICE NUMBER 2801629

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

or burial permit
Bd of Health
s Agent.

SUCTIONS
FOR
A CERTIFICATE

FOR TYPE
OR CAUSES
DEATH

ot enter
than one
for each
(b) and (c)

es not mean
e of dying,
heart failure,
etc. It means
e, or compli-
which caused

ions, if any,
have rise to
cause (a),
the under-
cause last.

itions contrib-
death but not
the terminal
ondition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 135

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Patrick Kelly
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No.

(a) Residence. No. 155 Pauline Street St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days. 8 Hrs.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH JULY (Month) 21 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from JAN, 19 54, to JULY 21, 19 62

I last saw him alive on JULY 20, 1962, death is said to have occurred on the date stated above, at 7:10 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) GENERAL CARCINOMATOSIS	3 1/2 Mo
Due To (b) CARCINOMA OF STOMACH	4 1/2 Mo
Due To (c)	
OTHER SIGNIFICANT CONDITIONS MYOCARDIAL DISEASE ARTERIO-SCLEROTIC HEART DIS	1 YR.

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL & X-ray.

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Myron N. King, M. D.
MYRON N. KING M.D.
(Print or Type Name)

(Address) 222 PLEASANT ST WINTHROP, MASS Date 7/21 1962

6 Place of Burial or Cremation Winthrop (City or Town)

DATE OF BURIAL July 24 1962

7 NAME OF FUNERAL DIRECTOR Frederick J Magrath

ADDRESS 325 Chelsea ST E. Boston

Received and filed JUL 23 1962 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced
HUSBAND of Elizabeth A. Mullen
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 68 Years.... Months.... Days — If under 24 hours ....Hours....Minutes

13 Usual Occupation: Steamship Clerk
(Kind of work done during most working life)

14 Industry or Business: Retired

15 Social Security No. CNBL

16 BIRTHPLACE (City) East Boston
(State or country) Mass

PARENTS

17 NAME OF FATHER Martin Kelly

18 BIRTHPLACE OF FATHER (City)
(State or country) Ireland

19 MAIDEN NAME OF MOTHER Mary Brennan

20 BIRTHPLACE OF MOTHER (City)
(State or country) Ireland

21 Informant Patricia E. Kelly
(Address) 155 Pauline St Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Lerrauer
(Signature of Agent of Board of Health or other)

Health Officer (Official Designation) 7/23/62 (Date of Issue of Permit)

52-932382

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FRM R-301

...or burial permit
...rd of Health
...s Agent.

...UCTIONS
OR
...CERTIFICATE

...OR TYPE
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...heart failure,
...etc. It means
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...ions, if any,
...ave rise to
...cause (a),
...the under-
...cause last.

...tions contrib-
...death but not
...the terminal
...ndition given

2-932382

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Winthrop
(City or Town making this return)

Registered No. 136

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. Bay View Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Sarah Whorf (Lee)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 94 Somerset Avenue St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 2 years 9 months days. In place of residence 70 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July (Month) 24 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from October 13, 1959, to July 24, 1962

I last saw he alive on July 24, 1962, death is said to have occurred on the date stated above, at 3:30 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

	INTERVAL BETWEEN ONSET AND DEATH
(a) Acute Myocardial Insufficiency	2 Days
Due To (b) Arteriosclerotic Heart Disease	1 Year
Due To (c) Generalized Arteriosclerosis	2 1/2 Years

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Dorothy Chaney Appleton, M. D.

Dorothy Chaney Appleton
(Print or Type Name)

(Address) 97 Woodside Ave. Winthrop, Mass. Date July 25 1962

6 Winthrop Cemetery Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL July 27, 1962 19

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed July 27, 1962

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female

9 COLOR white

10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) widowed

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Harry C. Whorf
(Husband's name in full)

12 AGE 90 Years 8 Month 29 Days | If under 24 hours Hours Minutes

13 Usual Occupation: housework WIFE
(Kind of work done during most working life)

14 Industry or Business: own home

15 Social Security No. none

16 BIRTHPLACE (City) Milford
(State or country) Maine

PARENTS

17 NAME OF FATHER James Lee

18 BIRTHPLACE OF FATHER (City) Pittston
(State or country) Maine

19 MAIDEN NAME OF MOTHER Nancy Stewart

20 BIRTHPLACE OF MOTHER (City) Charlestown
(State or country) Maine

21 Informant Richard C. Whorf
(Address) 375 North Saltair St. Hollywood, California

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Helen A. Lorenzini
(Signature of Agent of Board of Health or other)

Health Officer 7/26/62
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R-301

STRICTIONS
OR
AL CERTIFICATE

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... print or type
...der signature.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 137

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. 88 Brookfield Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME John R. Sullivan (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 88 Brookfield Road St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months....days. In place of residence 60 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 31, 1962 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
I last saw h....alive on ....., 19....., death is said to have occurred on the date stated above, at 7:35 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Sudden Death - Coronary Occlusion

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? no
What test confirmed diagnosis? none

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) John F. Collins M.D., M. D.
John F. Collins, M.D. (Print or Type Name)
(Address) 27 Bennington St. Revere, Mass. Date July 31, 1962

Winthrop Board of Health for —

6 St. Mary's Cemetery Lynn, Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 2, 1962

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
ADDRESS Winthrop, Mass.

Received and filed AUG 1 1962 19.....
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 CITIZEN OF U.S.	11 SINGLE ☐ MARRIED ☐ WIDOWED ☒ DIVORCED ☐ UNKNOWN ☐
Male	White	YES ☒ NO ☐	

11a If married, widowed, or divorced
HUSBAND of Katherine T. Cody (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

12 DATE OF BIRTH Oct 22, 1873

13 AGE 88 Years 9 Months 9 Days — If under 24 hours ....Hours....Minutes

14 Usual Occupation: Retired Superintendant (Kind of work done during most of working life)

15 Industry or Business: B.R.B.& L. RR.

16 Social Security No. .....

17 BIRTHPLACE (City) Lynn (State or country) Mass

PARENTS

18 NAME OF FATHER Jeremiah Sullivan

19 BIRTHPLACE OF FATHER (City) ..... (State or country) Ireland

20 MAIDEN NAME OF MOTHER Bridget Davis

21 BIRTHPLACE OF MOTHER (City) ..... (State or country) Ireland

22 Informant Ruth McCaffrey
(Address) 88 Brookfield Rd Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Alfred C. Lurvey
(Signature of Agent of Board of Health or other)
Health Officer 8/1/62
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

...-930213

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

MR-305

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Lexington
(City or town making return)

Registered No. 138

PLACE OF DEATH

1 Middlesex (County)

Lexington (City or Town)

No. 34 Fairlawn Lane St. {(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME PERCY H. MORTIMER
(If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No. 457 Shirley Street St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death - years - months 3 days. In place of residence ... years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 8, 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden Death- natural causes.
Coronary Occlusion; Coronary atherosclerosis; Heart Disease

5 Accident, suicide, or homicide (specify) ---

Date and hour of injury ------ 19...

If accidental, was injury causally related to the death? ...

Where did Injury occur? -----
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? -----
(Specify type of place)

Manner of Injury -----
(How did injury occur?)

Nature of Injury -----

While at work? ----- Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased no

If so, specify ...

(Signed) Joseph V. Di Rago, M.D., M. D.

(Address) Woburn, Mass. Date May 8, 62

7 Winthrop Cemetery, Winthrop
Place of Burial or Cremation. (City or Town)

DATE OF BURIAL May 11, 19 62

8 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.

ADDRESS 917 Bennington St. E.Boston

Received and filed AUG 17 1962 19...

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 CITIZEN OF U.S.	12 SINGLE ☐ MARRIED XX WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐
male	white	YES ☐ NO ☐	

12a If married, widowed, or divorced
HUSBAND of Katherine C. Morrissey
(Give maiden name of wife in full)

(or) WIFE of ...
(Husband's name in full)

13 DATE OF BIRTH

14 AGE 81 Years 10 Months 7 Days | If under 24 hours ... Hours ... Minutes

15 Usual Occupation: Machinist
(Kind of work done during most of working life)

16 Industry or Business: Ship building

17 Social Security No. 024 07 2779

18 BIRTHPLACE (City) (State or country) Boston, Massachusetts.

PARENTS

19 NAME OF FATHER Henry Mortimer

20 BIRTHPLACE OF FATHER (City) (State or country) Scotland

21 MAIDEN NAME OF MOTHER (CBL)

22 BIRTHPLACE OF MOTHER (City) (State or country) (CBL)

23 Informant Katherine C. Mortimer (Widow)
(Address) 457 Shirley St. Winthrop

A TRUE COPY.
ATTEST: James J. Carroll
(Registrar of City or Town where death occurred)

DATE FILED May 9, 19 62

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-3-61-930213

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE ..... AUG 1 7 1962 .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

FORM R-302

THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Chelsea (City or Town making this return)

Registered No. 356 139

PLACE OF DEATH

1 Suffolk (County)

Chelsea (City or Town)

No. Chelsea Memorial Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mollie Sinkovitz (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR,

(a) Residence. No. 29 Mermaid Ave. St. Winthrop, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death — year — month 10 days. In place of residence 60 years — months — days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 28, 1962 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from June 20, 62, to June 28, 62. I last saw her alive on June 27, 1962, 19..., death is said to have occurred on the date stated above, at 7:55 m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Cerebral thrombosis — 9 das.

Due To (b) Hypertension — ?

Due To (c) Hemiplegia — 4 yrs.

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? clinical signs

5 Was disease or injury in any way related to occupation of deceased? ..... If so, specify

(Signed) M.J.Greenfield, M. D.

(Address) Chelsea, Mass. Date 6/28/62

6 Community of Chelsea, Danvers, Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 29, 1962, 19...

7 NAME OF FUNERAL DIRECTOR B.S.Solomon

ADDRESS 420 Harvard Ave., Brookline, Mass.

Received and filed Aug. 24, 1962, 19...

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: Widowed

11 If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of William Sinkovitz (Husband's name in full)

12 Date of birth 1881 AGE 81 Years — Months — Days. If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife (Kind of work done during most working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) (State or country) Austria

PARENTS

17 NAME OF FATHER Abraham Waldman

18 BIRTHPLACE OF FATHER (City) (State or country) Austria

19 MAIDEN NAME OF MOTHER Ester Seidman

20 BIRTHPLACE OF MOTHER (City) (State or country) Austria

21 Informant Evelyn Sinkovitz (Address) 29 Mermaid Ave., Winthrop, Mass.

TRUE COPY ATTEST: Joseph A. Yurrelis (Registrar of City or Town where death occurred)

DATE FILED June 28, 1962, 19...

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT - OF - TOWN

To be filed for burial permit with Board of Health or its Agent. 140

Registered No. [illegible]

PLACE OF DEATH

1 Suffolk (County)
Boston (City or Town)
No. Veterans Administration Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Harry (First Name) Abrams (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) WWI

(a) Residence. No. 46 Bellevue Ave. (Usual place of abode) Winthrop, Mass. (If nonresident, give city or town and State)

Length of stay: In place of death 0 years 0 months 1 days. In place of residence ... years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July (Month) 24 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 23, 1962, to July 24, 1962, death is said to have occurred on the date stated above, at 9:50A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No
What test confirmed diagnosis? Clinical & Lab Findings

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Stephen A. Kulick, M. D.
Stephen A. Kulick (Print or Type Name)
(Address) VAH, Boston, Mass. Date July 24 1962

6 Pride of Boston Cem., Woburn, Mass. (Place of Burial or Cremation) (City or Town)
DATE OF BURIAL July 25 1962

7 NAME OF FUNERAL DIRECTOR Torf Funeral Chapel
ADDRESS 151 Washington Ave., Chelsea, Mass.

Received and filed JUL 25 1962
Charles H. [illegible] (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 CITIZEN OF U.S.: YES X NO
11 SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐ (S)

11a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

12 DATE OF BIRTH June 9, 1900

13 AGE 62 Years 1 Months 15 Days — If under 24 hours ... Hours ... Minutes

14 Usual Occupation: RETIRED SUPPLY OFFICER (Kind of work done during most of working life)

15 Industry or Business: RETIRED CIVILIAN - ARMY

16 Social Security No.

17 BIRTHPLACE (City) Boston (State or country) Mass.

PARENTS

18 NAME OF FATHER Jacob Abrams

19 BIRTHPLACE OF FATHER (City) (State or country) Russia

20 MAIDEN NAME OF MOTHER Mary Krutchinsky

21 BIRTHPLACE OF MOTHER (City) (State or country) Poland

22 Informant (Address) V. A. Hospital Records, 150 S. Huntington Ave., Boston, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

[illegible] (Signature of Agent of Board of Health or other)

B/2219 (Official Designation) 7-24-62 (Date of Issue of Permit)

R-301

TICTIONS IR L ERTIFICATE

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Medical Examiner Declines 5 28 1962

H201 81 X70

1-930213

T V.E.

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

AUG 2 8 1962 AM

RI R-301A

NRUCTIONS FOR C CERTIFICATE

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t Chapter 137, 1954, requires ins to print or ne cause or of death on rtificates, and 48, Acts of quires Physi- print or type ider signature.

-6-59-925686

The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 141

PLACE OF DEATH

1 County: Suffolk
City or Town: WINTHROP
No. WINTHROP CONVALESCENT HOME St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME GEMMA MARIA D'AGOSTINO (If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Residence. No. 168 GOVE STREET St. EAST BOSTON, MASS.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 2 years 5 months 20 days. In place of residence 42 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 1, 1962 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from MARCH 12 1960, to August 1, 1962
I last saw her alive on August 1, 1962, death is said to have occurred on the date stated above, at 8:20 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) ARTERIOSCLEROTIC HEART DISEASE	8yrs
Due To (b)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS OLD CEREBRO-VASCULA Accident	8yrs.

Was autopsy performed? NO
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) John F. Pepi, M. D.
(PRINT OR TYPE SIGNATURE) JOHN F. PEPI MD.
(Address) East Boston, mass. Date aug. 1, 1962

6 Place of Burial or Cremation HOLY CROSS MALDEN (City or Town)
DATE OF BURIAL AUG. 4, 1962

7 NAME OF FUNERAL DIRECTOR DIPIETRO & VAZZA
ADDRESS 11 HENRY ST, EAST BOSTON

Received and filed AUG 2 1962 19..
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE
9 COLOR WHITE
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) SINGLE

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 84 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation GARMENT FINISHER (RETIRED) (Kind of work done during most of working life)

14 Industry or Business CLOTHING FACTORY

15 Social Security No. NONE

16 BIRTHPLACE (City) (State or country) ITALY

PARENTS

17 NAME OF FATHER SABATINO D'AGOSTINO

18 BIRTHPLACE OF FATHER (City) (State or country) ITALY

19 MAIDEN NAME OF MOTHER ERINA D'AGRESTA

20 BIRTHPLACE OF MOTHER (City) (State or country) ITALY

21 Informant GIUSEPPE D'AGOSTINO
(Address) 168 GOVE ST, EAST BOSTON

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph L. Levanne
(Signature of Agent of Board of Health or other)

Health Officer 8/2/62
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-302

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

Somerville 112
(City or Town making this return)

COPY OF CERTIFICATE OF DEATH

Registered No. 433

PLACE OF DEATH

1 Middlesex (County)

Somerville (City or Town)

Little Sisters of the Poor
No. 186 Highland Avenue St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Nellie V. Johnson
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR, -----

(a) Residence. No. 35 Summitt Avenue St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death -- years 3 months 2 days. In place of residence 1 years -- months -- days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August (Month) 1, (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 1, 1962, to Aug. 1, 1962, I last saw alive on July 29, 1962 and death is said to have occurred on the date stated above, at 8:35A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma of Bowel (Large) — INTERVAL BETWEEN ONSET AND DEATH: 1yr

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS Generalized Arteriosclerosis unknown

Was autopsy performed? No

What test confirmed diagnosis? Clinical Evidence

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) John A. Fraser, M. D.
John A. Fraser, M.D.
(Address) 172 Summer St. Somerville, Mass. Date 8-2 62

Place of Burial or Cremation New Calvary Cem. Boston, Mass. (City or Town)

DATE OF BURIAL Aug. 4, 62

7 NAME OF FUNERAL DIRECTOR Joseph P. Murphy

ADDRESS 322 Bunker Hill St. Charlestown Mass

Received and filed SEP 10 1962 19

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: Single

11 If married, widowed, or divorced
HUSBAND of ----------
(Give maiden name of wife in full)
(or) WIFE of ----------
(Husband's name in full)

12 AGE 77 Years 9 Months 19 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Industrial Nurse
(Kind of work done during most working life)

14 Industry or Business: ----------

15 Social Security No. 025-09-6714

16 BIRTHPLACE (City) Boston
(State or country) Mass

PARENTS

17 NAME OF FATHER William H. Johnson

18 BIRTHPLACE OF FATHER (City)
(State or country) England

19 MAIDEN NAME OF MOTHER Bridget Keane

20 BIRTHPLACE OF MOTHER (City) Galway,
(State or country) Ireland

21 Informant Little Sisters of the Poor Record
(Address) 186 Highland Ave. Som.

TRUE COPY
ATTEST: William J. Donovan
(Registrar of City or Town where death occurred)

DATE FILED Aug. 2, 1962 19

M. C.

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

FORM R-301

d for burial permit
board of Health
its Agent.

TRUCTIONS
FOR
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T OR TYPE
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to death but not
to the terminal
condition given

M.C.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 143

PLACE OF DEATH

1 Suffolk (County)

Winthrop, (City or Town)

No. Mayflower Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Laura V. (Colburn) Garland (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 31 Villa Avenue St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months 21 days. In place of residence 12 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH AUG (Month) 6 (Day) 1962 (Year)

4 I HEREBY CERTIFY That I attended deceased from NOV 11, 1959, to AUG 6, 1962. I last saw he alive on AUG 6, 1962, death is said to have occurred on the date stated above, at 12 30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) ARTERIOSCLEROTIC HEART DS — 6 MO

Due To (b) GENERAL ARTERIOSCLEROSIS — 3 YRS

Due To (c)

OTHER SIGNIFICANT CONDITIONS NONE

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? NO

If so, specify

(Signature) Myron N. King M. D.

MYRON N. KING M.D. (Print or Type Name)

(Address) 272 PLEASANT ST WINTHROP Date 8/6 1962

6 Mt. Feake Cemetery, Waltham, Mass (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL August 8, 1962

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop

Received and filed AUG 7 1962 19....

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female

9 COLOR: white

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): widowed

11 If married, widowed, or divorced HUSBAND of ....

(Give maiden name of wife in full)

(or) WIFE of George Franklin Garland (Husband's name in full)

12 AGE 91 Years 7 Months 27 Days — If under 24 hours ....Hours....Minutes

13 Usual Occupation: Homemaker (Kind of work done during most working life)

14 Industry or Business: At home

15 Social Security No. none

16 BIRTHPLACE (City) Northhampton, Mass. (State or country)

PARENTS

17 NAME OF FATHER William Colburn

18 BIRTHPLACE OF FATHER (City) Wilton, Maine (State or country)

19 MAIDEN NAME OF MOTHER Laura Ann Chamberlain

20 BIRTHPLACE OF MOTHER (City) Ohio, New York (State or country)

21 Informant Colburn Olmstead (son) (Address) 291 Pearl St. Cambridge, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sweeney (Signature of Agent of Board of Health or other)

Health Officer (Official Designation) 8/7/62 (Date of Issue of Permit)

C 2-62-932382

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-303

61 for burial permit
Board of Health
its Agent.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-9-61-931348

X

PLACE OF DEATH

1 SUFFOLK (County)

WINTHROP (City or Town)

306 Revere Street, Winthrop
No. Jawn St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Winthrop (City or Town making this return)

Registered No. 141

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) NO.

2 FULL NAME ARTHUR (First Name) J. (Middle Name) WESTPHAL (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 306 Revere St., Winthrop (Usual place of abode) St. ~~Medford, Massachusetts~~ (If nonresident, give city or town and State)

Length of stay: In place of death.....years 3 months.....days. In place of residence.....years 3 months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August (Month) 6, (Day) 1962 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Coronary artery disease.

5 Accident, suicide, or homicide (specify)
Date and hour of injury .....19.....
IF ACCIDENTAL, was injury causally related to the death?
Where did Injury occur? (City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)
Manner of Injury (How did injury occur?)
Nature of Injury
While at work? Was autopsy performed? No.

6 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Michael A. Ludongo, M. D.
Michael A. Ludongo, M.D. (Print or Type Name)
(Address) Boston Date 8/7 19 62

7 Winthrop Cemetery Winthrop, Mass. Place of Burial, or Cremation. (City or Town)
DATE OF BURIAL August 9, 1962 19.....

8 NAME OF FUNERAL DIRECTOR Alfred B. Marsh
ADDRESS 174 Winthrop St. Winthrop, Mass.

Received and filed AUG 9 1962 19.....

A TRUE COPY ATTEST: [illegible]

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: male
10 COLOR: white
11 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): divorced

12 If married, widowed, or divorced
HUSBAND of June Gregory (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

13 DATE OF BIRTH June 5, 1900

14 AGE 62 Years 2 Months 1 Days | If under 24 hours .....Hours .....Minutes

15 Usual Occupation Self employed (Kind of work done during most of working life)

16 Industry or Business Veterinarian

17 Social Security No. 025-12-0950

18 BIRTHPLACE (City) Windsor (State or country) Canada

PARENTS
19 NAME OF FATHER William Westphal
20 BIRTHPLACE OF FATHER (City) Detroit (State or country) Michigan
21 MAIDEN NAME OF MOTHER Jeanette Nicholson
22 BIRTHPLACE OF MOTHER (City) Detroit (State or country) Michigan

23 Informant Carole Edwina McIntosh
(Address) 306 Revere St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other) Ralph E. Lareaume
(Official Designation) Health Officer (Date of Issue of Permit) 8/9/62

MEDICAL

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden death of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

FI R-301A

NSTRUCTIONS FOR C. CERTIFICATE

giving 3 OF DEATH

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ntions contrib- t death but not the terminal condition given

te Chapter 137, 1954, requires ons to print or e cause or s of death on ertificates.

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 145

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. Braemar Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Jennie Lydia (Browne) Anderson
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) No

V.A

~~11 Pleasant St.~~

(a) Residence. No. 17 Pleasant Street St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 6 years months days. In place of residence 40 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH AUGUST (Month) 11 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from MAY, 1940, to AUG. 11, 1962
I last saw he alive on AUG. 10, 1962, death is said to have occurred on the date stated above, at 6:10 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) BRONCHO PNEUMONIA	7 DAYS
Due To (b) SENILITY	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? NO
What test confirmed diagnosis?
5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signed) Louis F. Salerno, M. D.
(Address) 175 Pleasant St. Date Aug 11 1962

6 Winthrop Cemetery Winthrop
Place of Burial or Cremation (City or Town)
DATE OF BURIAL August 14, 1962

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh
ADDRESS 174 Winthrop St. Winthrop.

Received and filed AUG 13 1962 19
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female
9 COLOR white
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) widowed

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of John T. Anderson
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 99 Years 9 Months 27 Days | If under 24 hours Hours Minutes

13 Usual Occupation: House ~~work~~ wife
(Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No. None

16 BIRTHPLACE (City) (State or country) Burrillville, Rhode Island

PARENTS

17 NAME OF FATHER Charles M. Browne

18 BIRTHPLACE OF FATHER (City) (State or country) Burrillville, Rhode Island

19 MAIDEN NAME OF MOTHER Unable to obtain

20 BIRTHPLACE OF MOTHER (City) (State or country) Unable to obtain

21 Informant Edward R. Thomas
(Address) 22 Beacon St. Boston, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sartanni
(Signature of Agent of Board of Health or other)

Health Officer Aug. 13, 1962
(Official Designation) (Date of Issue of Permit)

50M-5-56-917573

EXTRACTS

FROM THE LAWS OF THE

COMMONWEALTH OF MASSACHUSETTS

GOVERNING THE

RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . .Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. — General Laws, Chap. 38, Sec. 6., as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made.
Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:—

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home, when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also those resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

'ORM R-301

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oard of Health
o its Agent.

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7. C.

1-62-932382

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 146

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. 109 Pleasant St., Winthrop St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME CATHERINE GALLAGHER
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 109 Pleasant Street St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 28 years ..... months ..... days. In place of residence 28 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August (Month) 11 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ——, 19..., to ——, 19...

I last saw h... alive on ——, 19..., death is said to have occurred on the date stated above, at 7:15 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Death presumably due

Due To (b) to natural causes,

Due To (c) senile changes, generalized

OTHER SIGNIFICANT CONDITIONS arterio sclerosis, Winthrop Board of Health

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed?

What test confirmed diagnosis? Charles Lieberman, M.D.

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Lieberman M. D.

CHARLES LIEBERMAN
(Print or Type Name)

(Address) Winthrop, Mass. Date 8/11/1962

6 Holy Cross Place of Burial or Cremation Malden (City or Town)

DATE OF BURIAL August 14, 1962

7 NAME OF FUNERAL DIRECTOR FRANK H. CARR

ADDRESS 79 Elm St., Charlestown, Mass.

Received and filed AUG 13 1962 19...

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: F

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Single

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 81 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Matron (retired)
(Kind of work done during most working life)

14 Industry or Business: Mass. General Hospital

15 Social Security No.

16 BIRTHPLACE (City) Donegal (State or country) Ireland

PARENTS

17 NAME OF FATHER Daniel F. Gallagher

18 BIRTHPLACE OF FATHER (City) Donegal (State or country) Ireland

19 MAIDEN NAME OF MOTHER Mary Bradley

20 BIRTHPLACE OF MOTHER (City) Dublin (State or country) Ireland

21 Informant John F. Gallagher
(Address) 109 Pleasant St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sirianni (MD)
(Signature of Agent of Board of Health or other)

Health Officer 8/13/62
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

'ORM R-301

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its Agent.

IITRUCTIONS
FOR
IIL CERTIFICATE

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to the terminal
condition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 147

PLACE OF DEATH

1 Suffolk (County) Revised 8-1-62

Winthrop (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Candia, Rose Rosina (Russo)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 789 Winthrop Ave., St. Revere, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Aug (Month) 12 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jul 1 1930, 19 62, to Aug 12, 19 62
I last saw he alive on Aug 12, 1962, death is said to have occurred on the date stated above, at 1 P.M. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Cerebro-Vascular Hemorrhage	10 min
Due To (b)	Arteriosclerosis - gen.	yrs
Due To (c)	Hypertension -	yrs
OTHER SIGNIFICANT CONDITIONS	Diabetes Mellitus	

Was autopsy performed?
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Joseph Gregorio, M. D.
Joseph Gregorio
(Print or Type Name)
(Address) 194 Washington St. Date 8/12 19 62

6 St. Michael Cemetery, Boston
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 15th 19 62

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc

ADDRESS 917 Bennington St., E. Boston

Received and filed AUG 14 1962 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Joseph Candia
(Husband's name in full)

12 AGE 64 Years 8 Months 10 Days | If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Stitcher
(Kind of work done during most working life)

14 Industry or Business: Factory

15 Social Security No. 028-03-3349

16 BIRTHPLACE (City) (State or country) Italy

PARENTS

17 NAME OF FATHER Frank Russo

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Henrietta (CBL)

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant Mr. Frank Candia-son
(Address) 4 Woods Road, Saugus, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sirmann (HS)
(Signature of Agent of Board of Health or other)

Health Officer 8/14/62
(Official Designation) (Date of Issue of Permit)

2-62-932382

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

RI R-301A

N RUCTIONS FOR C CERTIFICATE

giving S OF DEATH

d not enter c than one ate for each a (b) and (c)

is does not mean nle of dying, heart failure, ni etc. It means ease, or compli- s which caused

ions, if any, gave rise to n cause (a), ti the under- n, cause last.

Conditions contrib- death but not o the terminal condition given

N.C.

t - Chapter 137, 1954, requires ians to print or he cause or e of death on certificates, and 48, Acts of equires Physi- print or type nder signature.

DI-6-59-925686

The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 148

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. Mayflower Nursing Home St. {(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Giovanna Di Muro (Cianci) {(Was deceased a U. S. War Veteran, (if so specify WAR) no

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 39 Grovers Ave. St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 7 years ... months ... days. In place of residence 7 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 8 (Month) 12 (Day) 62 (Year)

4 I HEREBY CERTIFY, That I attended deceased from May 29, 1962, to August 12, 1962
I last saw he alive on August 12, 1962, death is said to have occurred on the date stated above, at 6 8 m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Gangrene Both Legs Progressive

Due To (b) ~~Parkinsonism~~ Arteriosclerosis

Due To (c)

INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS Parkinson's Disease 4 months

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? ...
If so, specify No

(Signed) S. A. DiLuca, M. D.
S. A. DeLuca M.D.
(PRINT OR TYPE SIGNATURE)
(Address) 550 Park Ave Winthrop Date 8/12 1962

6 Place of Burial or Cremation Winthrop Cemetery, Winthrop (City or Town)
DATE OF BURIAL Aug. 16, 1962

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano
ADDRESS 147 Winthrop St., Winthrop

Received and filed AUG 15 1962 19...
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female

9 COLOR white

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word) married

10a If married, widowed, or divorced
HUSBAND of ...
(Give maiden name of wife in full)
(or) WIFE of Anthony DiMuro
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 72 Years 7 Months 11 Days
If under 24 hours ... Hours ... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: at home

15 Social Security No. ...

16 BIRTHPLACE (City) Weymouth
(State or country) Mass.

PARENTS

17 NAME OF FATHER Frank Cianci

18 BIRTHPLACE OF FATHER (City) ...
(State or country) Italy

19 MAIDEN NAME OF MOTHER Rachaela ?

20 BIRTHPLACE OF MOTHER (City) ...
(State or country) Italy

21 Informant Jerome DiMuro
(Address) 30 Temple Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Tirrisano
(Signature of Agent of Board of Health or other)

Health Officer 8/15/62
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

ORM R-301

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NSTRUCTIONS
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condition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 149

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Michael DiFronzo (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 72 StAndrew Road St. East Boston Mass (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death ....years 1 months 8 days. In place of residence 32 years ....months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Aug (Month) 13 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 5, 1962, to Aug. 13, 1962. I last saw him alive on Aug 13, 1962 death is said to have occurred on the date stated above, at 11:56 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma of Sigmoid

Due to (b) Colon with Extension

Due to (c) into Urinary Bladder

OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH: 3 mos

Was autopsy performed? no

What test confirmed diagnosis? cp. 7/12/62

5 Was disease or injury in any way related to occupation of deceased? ....
If so, specify no

(Signature) R. C. Patto, M. D.
D. D. Patto MD
(Print or Type Name)

(Address) 12A Bennington St. East Boston Mass. Date 8/13 1962

6 Holy Cross Cemetery, Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 16th 1962

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.

ADDRESS 917 Bennington St., E.Boston

Received and filed AUG 14 1962 1962

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced
HUSBAND of Philomena Casoli
(Give maiden name of wife in full)
(or) WIFE of ....
(Husband's name in full)

12 AGE 79 Years 11 Months 28 Days — If under 24 hours ....Hours ....Minutes

13 Usual Occupation: Bartender
(Kind of work done during most working life)

14 Industry or Business: Taverns

15 Social Security No. 023-24-3538

16 BIRTHPLACE (City) (State or country) Italy

PARENTS

17 NAME OF FATHER Nicola DiFronzo

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Concetta Gregorio

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant Mr. Angelo DiFronzo-son
(Address) 70 Bickford Ave., Revere

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sirianni (HB)
(Signature of Agent of Board of Health or other)

Health Officer 8/14/62
(Official Designation) (Date of Issue of Permit)

-62-932382

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

l for burial permit
oard of Health
its Agent.

TRUCTIONS
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 150

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. Mount's ~~Rest~~ Convalescent Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME LuLu Sullivan (Hatch)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 3 Oak Island Rd. St. Revere
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 14 days. In place of residence 3 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August (Month) 20 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from June 20, 1962, to August 20, 1962. I last saw h alive on Aug 20, 1962, death is said to have occurred on the date stated above, at 3:25 P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Lymphosarcoma

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH

yr.

Was autopsy performed? No

What test confirmed diagnosis? Operation

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Harry J. Oliener, M. D.
HARRY J. OLIENER, M.D.
(Print or Type Name)

(Address) Revere, Mass. Date Aug 21 1962

6 Woodlawn Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 23, 1962

7 NAME OF FUNERAL DIRECTOR McGlinchey Funeral Home
By Leo M. Norton
ADDRESS 583 Broadway, Chelsea

Received and filed AUG 22 1962 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: Widowed

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Dennis Sullivan
(Husband's name in full)

12 AGE 45 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: At Home
(Kind of work done during most working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) Chelsea
(State or country)

PARENTS

17 NAME OF FATHER: Carl Hatch

18 BIRTHPLACE OF FATHER (City) N. Hampshire
(State or country)

19 MAIDEN NAME OF MOTHER: Olie Rowell

20 BIRTHPLACE OF MOTHER (City) Newburyport
(State or country)

21 Informant William E Hatch
(Address) 177 Central Ave. Chelsea

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Giannini (MD)
(Signature of Agent of Board of Health or other)

Vital Office Aug. 22, 1962
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

P-62-932382

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

ill for burial permit
board of Health
its Agent.

NSTRUCTIONS
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 151

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME William Baron
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 19 Beach Road St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months 1 days. In place of residence 3 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Aug. (Month) 21 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from June, 1959, to Aug. 21, 1962
I last saw him alive on Aug. 20, 1962, death is said to have occurred on the date stated above, at 4:45 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Coronary Artery Heart Disease	1 yr.
Due To (b)	Arteriosclerosis.	2 yrs.
Due To (c)		

OTHER SIGNIFICANT CONDITIONS None.

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS. Date 8/21/1962

6 Ohavey Zedek West Roxbury
Place of Burial or Cremation (City or Town)
DATE OF BURIAL August 22 1962

7 NAME OF FUNERAL DIRECTOR Paul R. Levine
ADDRESS 470 Harvard St., Brookline

Received and filed AUG 21 1962 19....
John A. Clark
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Married

11 If married, widowed, or divorced
HUSBAND of Etta Pollack
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 77 Years.....Months.....Days
If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Salesman
(Kind of work done during most working life)

14 Industry or Business: Hardware

15 Social Security No. cannot be learned

16 BIRTHPLACE (City) Russia
(State or country)

PARENTS
17 NAME OF FATHER Sholom Baron
18 BIRTHPLACE OF FATHER (City) Russia
(State or country)
19 MAIDEN NAME OF MOTHER Esther Tock
20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)

21 Informant Mrs. Etta Baron
(Address)
19 Beach Rd., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Paul E. Liriani
(Signature of Agent of Board of Health or other)
Health Officer 8/21/62
(Official Designation) (Date of Issue of Permit)

M-62-932382

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R-305

THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-3-61-930213

318

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Revere
(City or town making return)

Registered No. 152

PLACE OF DEATH

1 Suffolk (County)

Revere (City or Town)

No. On sidewalk at 184 Broadway, Revere St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Alfonso Celata (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 573 Pleasant St. Winthrop, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 11 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August (Month) 21, (Day) 1962 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Coronary Occlusion.

5 Accident, suicide, or homicide (specify)

Date and hour of injury .....19.....

If accidental, was injury causally related to the death?

Where did Injury occur? (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)

Manner of Injury (How did injury occur?)

Nature of Injury

While at work? Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Michael A. Luongo M. D.

(Address) Boston Date 8/21/ 19 62

7 Holy Cross Cemetery, Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 24, 19 62

8 NAME OF FUNERAL DIRECTOR Lillian Cataldo

ADDRESS 374 Broadway, Som., Mass.

Received and filed AUG 1962 19.....
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male

10 COLOR White

11 CITIZEN OF U.S. YES ☐ NO ☐

12 SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐ married

12a If married, widowed, or divorced
HUSBAND of Esther DeLuca
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

13 DATE OF BIRTH

14 AGE 59 Years.....Months.....Days If under 24 hours .....Hours .....Minutes

15 Usual Occupation: Foreman Construction
(Kind of work done during most of working life)

16 Industry or Business: Appel Construction Roxbury

17 Social Security No.

18 BIRTHPLACE (City) Boston (State or country) Mass.

PARENTS

19 NAME OF FATHER Michael Celata

20 BIRTHPLACE OF FATHER (City) (State or country) Italy

21 MAIDEN NAME OF MOTHER Josephine Rizzo

22 BIRTHPLACE OF MOTHER (City) (State or country) Italy

23 Informant Esther Celata
(Address) 373 Pleasant St., Winthrop

A TRUE COPY.
ATTEST: [signature]
(Registrar of City or Town where death occurred)

DATE FILED August 24, 19 62

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

ORM R-301

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NSTRUCTIONS
FOR
CERTIFICATE

OR TYPE
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condition given

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 153

PLACE OF DEATH

1 Suffolk (County), Winthrop (City or Town)

Boston 8-7-62

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Alice H. Greer (Maiden Flynn)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 93 Trenton St. E. Boston, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months 3 days. In place of residence 79 years 8 months 9 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August (Month) 21 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 17, 1962, to Aug 21, 1962

I last saw he alive on Aug 20, 1962, death is said to have occurred on the date stated above, at 11:10 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: yrs

Due To (b) Arteriosclerosis generalized — yrs

Due To (c) senility

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Joseph Gregorie M. D.
JOSEPH GREGORIE
(Print or Type Name)
(Address) 194 Washington Winthrop Date 8/21 1962

6 Holy Cross Cemetery, Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 24th 1962

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.

ADDRESS 917 Bennington St., E. Boston

Received and filed AUG 22 1962

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: F

9 COLOR: W

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Frank B. Greer
(Husband's name in full)

12 AGE 79 Years 8 Months 9 Days — If under 24 hours ....Hours....Minutes

13 Usual Occupation: Housewife
(Kind of work done during most working life)

14 Industry or Business: At home

15 Social Security No. None

16 BIRTHPLACE (City) East Boston
(State or country) Mass.

PARENTS

17 NAME OF FATHER William J. Flynn

18 BIRTHPLACE OF FATHER (City) Boston
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Katherine Welth

20 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Mass.

21 Informant Rico Matera-Attorney
(Address) 163 Meridian Street, East Boston, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sirianni (HO)
(Signature of Agent of Board of Health or other)

Health Officer 8/22/62
(Official Designation) (Date of Issue of Permit)

62-932382

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

ORM R-301

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N RUCTIONS
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N OR TYPE
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ions, if any, gave rise ta cause (a), the under- cause last.

Conditions contrib- death but nat do the terminal condition given

T. C.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

4
(City or Town making this return)

Registered No. 154

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Celia (Markell) Rubin
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 19 Nevada St St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ... years ... months ... days. In place of residence 42 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August (Month) 22 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Oct 1950, 19..., to Aug 22, 19 62

I last saw he alive on Aug 22, 19 62 death is said to have occurred on the date stated above, at 11:30 P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

Due To (b) arteriosclerotic heart disease

Due To (c)

OTHER SIGNIFICANT CONDITIONS Congestive heart failure

Was autopsy performed? No

What test confirmed diagnosis? —

5 Was disease or injury in any way related to occupation of deceased? ...
If so, specify No

(Signature) H. B. Greenfield, M. D.
H B Greenfield
(Print or Type Name)
(Address) 4478 Washington Mass Date Aug 22 19 62

6 Ohel Jacob Woburn
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 23 19 62

7 NAME OF FUNERAL DIRECTOR Arnold Golor

ADDRESS 1665 Beacon st Brookline

Received and filed August 23, 19 62

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Married

11 If married, widowed, or divorced
HUSBAND of ...
(Give maiden name of wife in full)
(or) WIFE of Dr. Maurice S. Rubin
(Husband's name in full)

12 AGE 70 Years ... Months ... Days
If under 24 hours ... Hours ... Minutes

13 Usual Occupation: House work
(Kind of work done during most working life)

14 Industry or Business: At home

15 Social Security No. ...

16 BIRTHPLACE (City) Russia
(State or country)

PARENTS

17 NAME OF FATHER Israel Markell

18 BIRTHPLACE OF FATHER (City) Russia
(State or country)

19 MAIDEN NAME OF MOTHER C. b. I.

20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)

21 Informant Solomon Rubin
(Address) 118 Bainbridge St Malden

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Ralph E. Sirianni (NH)
(Signature of Agent of Board of Health or other)
Health Officer
(Official Designation)
8/23/62
(Date of Issue of Permit)

62-93282

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

ill for burial permit
board of Health
its Agent.

INSTRUCTIONS FOR
NAL CERTIFICATE

IT OR TYPE
S OR CAUSES
O DEATH

d not enter
e than one
e for each
(b) and (c)

*does not mean
de of dying,
heart failure,
etc. It means
ease, or compli-
which caused*

*ntions, if any,
gave rise to
cause (a),
the under-
cause last.*

*Conditions contrib-
death but not
to the terminal
condition given*

1-62-932382

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 155

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Sylvia Minkin Freedman
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No. 38 Forrest St St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months 20 days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 8 (Month) 25 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb, 1961 to Aug. 25, 1962
I last saw he alive on Aug. 25, 1962, death is said to have occurred on the date stated above, at 10:30 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Glomerulo-nephritis — 15 yrs.
Due To
(b)
Due To
(c)
OTHER SIGNIFICANT CONDITIONS: Uremia 1½ yrs; Hypertension 1½ yrs.; Anemia 1½ yrs

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS Date 8/25/1962

6 ~~Beth El (Lebanon)~~ SHARA TFILO West Roxbury
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 26, 1962

7 NAME OF FUNERAL DIRECTOR Benjamin F. Solomon

ADDRESS 420 Harvard Street, Brookline.

Received and filed AUG 27 1962 19....

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: white
10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word): married

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Morris Freedman
(Husband's name in full)

12 AGE 42 Years.....Months.....Days — If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Housewife
(Kind of work done during most working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) Worcester, Mass.
(State or country)

PARENTS

17 NAME OF FATHER Israel Minkin

18 BIRTHPLACE OF FATHER (City) Cincinnati,
(State or country) Ohio

19 MAIDEN NAME OF MOTHER Ann (unknown)

20 BIRTHPLACE OF MOTHER (City)
(State or country) Russia

21 Informant Morris Freedman
(Address) 38 Forrest Street, Winthrop, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

ORM R-301

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RUCTIONS
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CATE CERTIFICATE

N OR TYPE
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DEATH

lo not enter
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c gave rise to
u cause (a),
in the under-
g cause last.

Conditions contrib-
d death but not
d the terminal
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M.C.

52-932382

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Winthrop
(City or Town making this return)

Registered No. 156

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. 46 Washington Ave. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

2 FULL NAME John J. Kennedy
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 20 Cora St. St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years 4 months ....days. In place of residence 60 years ....months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Aug. (Month) 25 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from June, 1948 to Aug. 25, 1962
I last saw him alive on August 25, 1962, death is said to have occurred on the date stated above, at 7:15 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Myocardial heart disease	yrs.
Due To (b) arteriosclerosis, generalized	yrs.
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Senility	yrs.

Was autopsy performed?
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Joseph Gregorie, M. D.
Joseph Gregorie, M.D.
(Print or Type Name)
(Address) 194 Washington Ave. Date 8/26/ 1962

6 Winthrop Cemetery Winthrop
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Aug. 28 1962

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
ADDRESS Winthrop, Mass.

Received and filed AUG 27 1962 1962
John Clark
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced
HUSBAND of Ellen Boyle
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 95 Years ....Months ....Days
If under 24 hours ....Hours ....Minutes

13 Usual Occupation: Consultant
(Kind of work done during most working life)

14 Industry or Business: Winthrop Sewer Dep't

15 Social Security No.

16 BIRTHPLACE (City) Boston
(State or country) Mass.

PARENTS
17 NAME OF FATHER John Kennedy
18 BIRTHPLACE OF FATHER (City)
(State or country) Ireland
19 MAIDEN NAME OF MOTHER Mary ----
20 BIRTHPLACE OF MOTHER (City)
(State or country) Ireland

21 Informant Helen Franklin
(Address) 20 Cora St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Ralph E. Lincoln (NB)
(Signature of Agent of Board of Health or other)
Health Officer 8/27/62
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

OM R-303

le for burial permit
l ard of Health
o ts Agent.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-9-61-931348

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

(City or Town making this return)

Registered No. 157

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME LESLIE N. BROWN (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. ~~30~~ 26 Nevada St., Winthrop, Mass. St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August (Month) 26, (Day) 1962 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Hypertensive cardio-vascular disease; occlusive coronary arteriosclerosis; acute pulmonary edema

5 Accident, suicide, or homicide (specify)

Date and hour of injury .....19.....

IF ACCIDENTAL, was injury causally related to the death?

Where did Injury occur? (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place) Collapsed while operating motor car.

Manner of Injury (How did injury occur?)

Nature of Injury

While at work? Was autopsy performed? Yes

6 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Michael A. Lubngo, M. D.
Michael A. Lubngo, M.D.
(Print or Type Name)

(Address) Boston, Mass. Date 8/26 19 62

7 David Vicur Choulin (Lebanon) W. Roxbury
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL August 27, 19 62

8 NAME OF FUNERAL DIRECTOR Benjamin F. Solomon

ADDRESS 420 Harvard Street, Brookline

Received and filed AUG 27 1962 19.....
John A. Clark

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN
male	white	married

12 If married, widowed, or divorced HUSBAND of Rose Gross
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

13 DATE OF BIRTH

14 AGE 67 Years.....Months.....Days If under 24 hours .....Hours .....Minutes

15 Usual Occupation Owner
(Kind of work done during most of working life)

16 Industry or Business: ~~Owner~~ Laundry

17 Social Security No.

18 BIRTHPLACE (City) Boston, (State or country) Mass.

PARENTS

19 NAME OF FATHER William Brown

20 BIRTHPLACE OF FATHER (City) Boston, (State or country) Mass.

21 MAIDEN NAME OF MOTHER Annie (Peyser)

22 BIRTHPLACE OF MOTHER (City) Boston, (State or country) Mass.

23 Informant Edmund Brown
(Address) 20 Myrtle Avenue, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sirvonne (MB)
(Signature of Agent of Board of Health or other)

02719
(Official Designation)

Aug 26 1962
(Date of Issue of Permit)

MEDICAL

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

ORM R-301

ih for burial permit
board of Health
o.ts Agent.

IN RUCTIONS FOR IC. CERTIFICATE

IN' OR TYPE
SI OR CAUSES
O. DEATH

d not enter
nc: than one
ate for each
s (b) and (c)

isoes not mean nde of dying, heart failure, m etc. It means ease, or compli- ns which caused

nions, if any, ic gave rise to cause (a), ti the under- ng cause last.

Conditions contrib- death but not ed o the terminal se condition given i)

, c.

62-932382

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 158

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Jessie MacFARLANE
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No. 9 Grovers Ave, Winthrop St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 1 years 1 months days. In place of residence 4 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Aug (Month) 26 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 26, 1962, to Aug 26, 1962, I last saw her alive on Aug 26, 1962, death is said to have occurred on the date stated above, at 7:45 P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myocardial Heart Disease — INTERVAL BETWEEN ONSET AND DEATH 4yr.

Due To (b) Arteriosclerosis - generalized — 4yr.

Due To (c)

OTHER SIGNIFICANT CONDITIONS Diabetes Mellitus, Gangrene - Right Toe — 4yr

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Joseph Gregorie M. D.
Joseph Gregorie M.D.
(Print or Type Name)
(Address) 194 Washington St. Date 8-26 1962

6 Cambridge Cem Cambridge
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 29 1962

7 NAME OF FUNERAL DIRECTOR A. J. Long & Son Inc.

ADDRESS 1979 Mass. Ave., Cambridge

Received and filed AUG 27 1962 1962

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Married

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of William A. MacFarlane
(Husband's name in full)

12 AGE 78 Years 2 Months 7 Days — If under 24 hours Hours Minutes

13 Usual Occupation: Housewife
(Kind of work done during most working life)

14 Industry or Business:

15 Social Security No. none

16 BIRTHPLACE (City) Prince Ed. Island
(State or country)

PARENTS

17 NAME OF FATHER Alexander Gillis

18 BIRTHPLACE OF FATHER (City) cannot be learned
(State or country)

19 MAIDEN NAME OF MOTHER Katherine Macleod cannot be learned

20 BIRTHPLACE OF MOTHER (City) cannot be learned
(State or country)

21 Informant Mrs. Grace Milne
(Address) 9 Grovers Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Joseph E. Siriani (MD)
(Signature of Agent of Board of Health or other)

Vital Office 8/27/62
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

F1 R-301

S UCTIONS FOR A CERTIFICATE

ligiving EDF DEATH

ot enter than one for each b) and (c)

es not mean of dying, heart failure, etc. It means or compli- which caused

ins, if any, ave rise to cause (a), the under- cause last.

ions contrib- death but not the terminal ndition given

ol:- Chapter 137, 1954 requires ians to print or the cause or e of death on th ertificates, and pr 48, Acts of , equires Physi- so print or type ender signature.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 159

PLACE OF DEATH

1 SUFFOLK (County)

WINTHROP (City or Town)

No. 58 BUCHANAN ST St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME JAMES TYLER McEACHERN (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Residence, No. 58 BUCHANAN ST. WINTHROP St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 50 years — months — days. In place of residence 50 years — months — days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH AUG. 26 1962 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Apr 20, 1960, to AUG 26, 1962

I last saw him alive on AUG 21, 1962, death is said to have occurred on the date stated above, at 8:05 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) GENERAL CARCINOMATOSIS	6 MO.
Due To (b) CARCINOMA OF RECTUM	2 3/4 YRS
Due To (c)	
OTHER SIGNIFICANT CONDITIONS HYPERTROPHY OF PROSTATE	6 MO.

Was autopsy performed? No.
What test confirmed diagnosis? CLINICAL & OPERATION

5 Was disease or injury in any way related to occupation of deceased? No.
If so, specify —

(Signed) Myron N. King, M. D.
MYRON N. KING M.D. (Print or Type Name)
(Address) 211 PLEASANT ST WINTHROP Date AUG 28 1962

6 WINTHROP CEM. WINTHROP Place of Burial or Cremation (City or Town)
DATE OF BURIAL AUG. 29 1962

7 NAME OF FUNERAL DIRECTOR Maurice H. Kirby
ADDRESS 210 WINTHROP ST. WINTHROP

Received and filed AUG 28 1962 19.....
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 CITIZEN OF U.S.	11 SINGLE ☐ MARRIED ☑ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐
Male	White	YES ☑ NO ☐	

11a If married, widowed, or divorced HUSBAND of AGNES ROCK (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

12 DATE OF BIRTH DEC. 7 1884

13 AGE 78 Years — Months — Days. If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: WATER DEPT - WINTHROP (Kind of work done during most of working life)

15 Industry or Business: Town WINTHROP ~~WATER~~ DEPT.

16 Social Security No. NOT KNOWN

17 BIRTHPLACE (City) (State or country) NOVA SCOTIA

PARENTS

18 NAME OF FATHER JOHN McEACHERN

19 BIRTHPLACE OF FATHER (City) (State or country) NOVA SCOTIA

20 MAIDEN NAME OF MOTHER NOT KNOWN

21 BIRTHPLACE OF MOTHER (City) (State or country) NOVA SCOTIA

22 Informant AGNES T. TYLER
(Address) 58 BUCHANAN ST. WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Joseph E. Liriani (NS)
(Signature of Agent of Board of Health or other)

Health Officer 8/28/62
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

DRM R-301

e for burial permit
Bard of Health
rts Agent.

RUCTIONS
FOR
CERTIFICATE

N OR TYPE
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F DEATH

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(b) and (c)

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me of dying,
heart failure,
etc. It means
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which caused

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cause (a),
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ditions contrib-
death but not
the terminal
ndition given

1 C.

3-2-932382

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 160

1 PLACE OF DEATH: Suffolk (County) — Winthrop (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Theodore Mortimer Northrop
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No. 69 Birch Rd. St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months 8 days. In place of residence 15 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August (Month) 26 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from April, 1956, to August 26, 1962

I last saw him alive on Aug 26 1962, death is said to have occurred on the date stated above, at 1:45 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) myocardial infarction

Due To (b) arteriosclerotic heart disease

Due To (c) Congestive heart failure

OTHER SIGNIFICANT CONDITIONS diabetes mellitus

INTERVAL BETWEEN ONSET AND DEATH: 7yrs.

Was autopsy performed? No

What test confirmed diagnosis? X-Rays

5 Was disease or injury in any way related to occupation of deceased? ....
If so, specify No

(Signature) H.B. Duenfeld, M. D.
H.B. Duenfeld
(Print or Type Name)
(Address) 147 Shirley Ave Date Aug 26 1962

6 Place of Burial or Cremation: Winthrop Cemetery, Winthrop (City or Town)

DATE OF BURIAL Aug. 29, 1962

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano
ADDRESS 147 Winthrop St., Winthrop

Received and filed AUG 28 1962 19....

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: male

9 COLOR: white

10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word): widowed

11 If married, widowed, or divorced
HUSBAND of Amy Johnson
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 72 Years....Months....Days — If under 24 hours ....Hours....Minutes

13 Usual Occupation: Retired Police Officer
(Kind of work done during most working life)

14 Industry or Business: Town of Winthrop

15 Social Security No.

16 BIRTHPLACE (City) Wickford
(State or country) Rhode Island

PARENTS

17 NAME OF FATHER Theodore Northrop

18 BIRTHPLACE OF FATHER (City)
(State or country) Rhode Island

19 MAIDEN NAME OF MOTHER Frances ?

20 BIRTHPLACE OF MOTHER (City)
(State or country) Rhode Island

21 Informant Charles Northrop
(Address) 34 Sunnyside Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Tirah E. Lisanna (Th3)
(Signature of Agent of Board of Health or other)

Vital Officer 8/28/62
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

M R-301A

NSTRUCTIONS FOR ICL CERTIFICATE

1 giving S OF DEATH

d not enter re than one a e for each (a), (b) and (c)

n does not mean ode of dying, heart failure, n etc. It means disease, or compli- ns which caused

ions, if any, h gave rise to cause (a), the under- n cause last.

ditions contrib- g death but not eto the terminal condition given a

t Chapter 137, 1954, requires sians to print or he cause or of death on certificates, and t 48, Acts of equires Physi- s print or type nder signature.

5-11-59-926662

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 161

PLACE OF DEATH

1 (County) Suffolk

(City or Town) Winthrop

No. Winthrop Community Hosp. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT!

2 FULL NAME JOHN POLINO (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) WORLD WAR I YES

(a) Residence. No. 922 NORTH SHORE RD. St. REVERE MASS. (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death.....years.....months 40 days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 27, 1962 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 18, 1962, to August 28, 1962

I last saw h. alive on August 26, 1962, death is said to have occurred on the date stated above, at 4:15 A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) CARCINOMA OF PROSTATE WITH Generalized Metastasis — 7½ yrs

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS Diabetis MELLITUS — 1 YR

Was autopsy performed? No

What test confirmed diagnosis? Surgery 7½ yrs ago

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) John F. Pepi, M. D.
John F. Pepi, M.D.
(PRINT OR TYPE SIGNATURE)

(Address 821 Saratoga St. E. B. Date Aug. 27, 1962

6 Place of Burial or Cremation St. Michael Cemetery (City or Town) Boston

DATE OF BURIAL August 29, 1962

7 NAME OF FUNERAL DIRECTOR Vincent Rapino

ADDRESS 9 Chelsea St., East Boston, Mass.

Received and filed AUG 28 1962 (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX male

9 COLOR white

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) widowed

10a If married, widowed, or divorced HUSBAND of Antonette Arciero (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 67 Years.....Months.....Days — If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Retired (Kind of work done during most of working life)

14 Industry or Business: *******

15 Social Security No. 010-10-3361

16 BIRTHPLACE (City) (State or country) Italy

PARENTS

17 NAME OF FATHER Angelo Polino

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Catherine (unknown)

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant Mary Polino (daughter)
(Address 922 No. Shore Rd., Revere, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Patrick E. Lucania (Signature of Agent of Board of Health or other) (H/S)

Health Officer (Official Designation) 8/28/62 (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE ..... April 26, 1918

DATE OF DISCHARGE ..... July 7, 1919

RANK, RATING ..... Private

ORGANIZATION AND OUTFIT ..... U.S. Army, Co. L 339th Inf.

SERVICE NUMBER 2043575

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

ORM R-301

for burial permit
oard of Health
its Agent.

RUCTIONS
FOR
. CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
e than one
e for each
, (b) and (c)

does not mean
de of dying,
heart failure,
, etc. It means
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cause (a),
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death but not
to the terminal
condition given

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5 - 1962

-62-932382

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

162

OUT - OF - TOWN
(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 07787

PLACE OF DEATH

1 SUFFOLK (County)

BOSTON, MASS (City or Town)

No. PETER BENT BRIGHAM HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Matthew Mc Donald
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 16 Johnson Ave. sx Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months 23 days. In place of residence 39 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August (Month) 7, (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 15, 1962, to Aug. 7, 1962, I last saw him alive on Aug. 7, 1962, death is said to have occurred on the date stated above, at 7:57 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Myelogenous Leukemia with

Due To (b) leukemic Infiltrate to Liver and Spleen

Due To (c) Pyonephrosis

OTHER SIGNIFICANT CONDITIONS Bronchopneumonia

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signature) P. J. Snodgrass, M. D.
DR. PHILIP SNODGRASS
(Print or Type Name)
PETER BENT BRIGHAM HOSP. Date 8/7 1962

6 Winthrop Cemetery Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 9, 1962

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby Inc.

ADDRESS 917 Bennington St. E. Boston

Received and filed AUG 10 1962 19..

Charles H. Mackie (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: M

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Married

11 If married, widowed, or divorced
HUSBAND of Mary A. Shaughnessy
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 82 Years.....Months.....Days
If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Contractor
(Kind of work done during most working life)

14 Industry or Business: Painting and Decorating

15 Social Security No.

16 BIRTHPLACE (City) (State or country) East Boston

PARENTS

17 NAME OF FATHER Charles McDonald

18 BIRTHPLACE OF FATHER (City) (State or country) Nova Scotia

19 MAIDEN NAME OF MOTHER Hanna Sullivan

20 BIRTHPLACE OF MOTHER (City) (State or country) Nova Scotia

21 Informant (Address) Mrs. Mary A. McDonald
16 Johnson Ave. Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

R. J. Rogerson Jr
(Signature of Agent of Board of Health or other)

12418 (Official Designation) 8/8/62 (Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

ORM R-301

le for burial permit
oard of Health
or its Agent.

IN RUCTIONS
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F 5 - 1962

-62-932362

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

163

OUT - OF - TOWN
(City or Town making this return)

Registered No. 078821

PLACE OF DEATH

1 Suffolk (County)

Boston (City or Town)

No. New England Center Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Louis Yavner
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 29 Pico Ave., Winthrop, Mass. St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months....33 days. In place of residence 8 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August (Month) 8 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 6, 1962, to August 8, 1962

I last saw h....alive on August 8, 62, death is said to have occurred on the date stated above, at 2:30a m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) RENAL FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 1 MO.

Due To (b) GLOMERULONEPHRITIS — 4 MOS.

Due To (c)

OTHER SIGNIFICANT CONDITIONS DIABETES MELLITUS

Was autopsy performed? YES
What test confirmed diagnosis? RENAL BIOPSY

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) Matthew E. Levine, M. D.
MATTHEW E. LEVINE
(Print or Type Name)

(Address) NEW ENGLAND CENTER HOSPITAL Date 8/8 1962

6 Dor. Hebrew Helping Hand, Everett
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 10 1962

7 NAME OF FUNERAL DIRECTOR Henry Levine

ADDRESS 470 Harvard St., Brookline

Received and filed AUG 13 1962 19....

Charles H. Mackie
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Married

11 If married, widowed, or divorced
HUSBAND of Sarah Chick
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 76 Years....Months....Days. If under 24 hours ....Hours....Minutes

13 Usual Occupation: Cutter
(Kind of work done during most working life)

14 Industry or Business: men's clothing

15 Social Security No. 011-05-8123

16 BIRTHPLACE (City) Russia
(State or country)

PARENTS

17 NAME OF FATHER: Joshua Yavner

18 BIRTHPLACE OF FATHER (City) Russia
(State or country)

19 MAIDEN NAME OF MOTHER: (unknown)

20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)

21 Informant Mrs. Sarah Yavner
(Address) 29 Pico Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

R. K. Garman
(Signature of Agent of Board of Health or other)

B 12435 (Official Designation) 8-9-62 (Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

ORM R-301

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or a Agent.

RUCTIONS
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Conditions contrib-
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CT 5 - 1962

62-932382

X

The Commonwealth of Massachusetts

164

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT - OF - TOWN
(City or Town making this return)

Registered No. 179999

PLACE OF DEATH

1 SUFFOLK (County)

BOSTON (City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

Cardy
Cardy

2 FULL NAME Irving C. Baker
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) NO.

(a) Residence. No. 174 Cottage Park Road (Usual place of abode) St. Winthrop, Massachusetts (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months 2 days. In place of residence 48 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 12, 1962 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from August 10 1962, to August 12, 1962 and last saw him alive on August 12, 1962 death is said to have occurred on the date stated above, at 4:05 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

	INTERVAL BETWEEN ONSET AND DEATH
(a) Pulmonary atelectasis	1 hour
Due To (b) Myasthemia gravis	2 Years
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? yes
What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signature) Chas. L. Clay, M. D.
Charles L. Clay, M.D. (Print or Type Name)
(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date Aug. 12 1962

6 Woodlawn Cemetery Everett, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL August 16, 1962 19....

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop Street, Winthrop, Mass.

Received and filed AUG 16 1962 19....

Charles H. Mackie
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: male
9 COLOR: white
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): married

11 If married, widowed, or divorced
HUSBAND of Winifred Knowles
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 AGE 78 Years 2 Months 13 Days | If under 24 hours ....Hours....Minutes

13 Usual Occupation: Retired salesman
(Kind of work done during most working life)

14 Industry or Business: Wholesale Electrical Supplies

15 Social Security No. 324-05-8358

16 BIRTHPLACE (City) Chelsea
(State or country) Mass.

PARENTS

17 NAME OF FATHER Charles Woodbury Baker

18 BIRTHPLACE OF FATHER (City) Chelsea
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Annie Florence Cardy

20 BIRTHPLACE OF MOTHER (City) Chelsea
(State or country) Mass.

21 Informant Mrs. Irving C. Baker
(Address) 174 Cottage Park Rd. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Raymond J. Rogerson
(Signature of Agent of Board of Health or other)

D-494 8/15/62.
(Official Designation) (Date of Issue of Permit)

RUE COPY ATTEST:

Charles H. Mackie

City Registrar

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 165

PLACE OF DEATH

1 Suffolk (County)
Winthrop (City or Town)
No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Baby Girl Vitello (If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No. 310 Princeton St. (Usual place of abode) St. East Boston Mass (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months 2 days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept. 3, 1962 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1962, to Sept. 3, 1962.
I last saw he alive on Sept 3, 1962, death is said to have occurred on the date stated above, at 1:40 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Prematurity 34th wks.
Birth weight 4 lbs. 2 oz.

INTERVAL BETWEEN ONSET AND DEATH: 2 days

Due To (b)

Due To (c)

Hydrocephalus

OTHER SIGNIFICANT CONDITIONS Hydrocephalus
Phocomelia

Was autopsy performed?
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) A. Paul Derhagopian, M. D.
A. Paul DERHAGOPIAN
(PRINT OR TYPE SIGNATURE)
(Address) 39 Cary Av. Chelsea Date Sept 3, 1962

6 St. Tarcisius Cemetery Framingham, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Sept. 4, 1962

7 NAME OF FUNERAL DIRECTOR Vincent Kapino
ADDRESS 9 Chelsea St., East Boston, Mass.

Received and filed Sep 4 1962 19..
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female
9 COLOR white
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) single

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 2 Years Months Days
If under 24 hours Hours Minutes

13 Usual Occupation: none (Kind of work done during most of working life)

14 Industry or Business: ****

15 Social Security No. none

16 BIRTHPLACE (City) (State or country) Winthrop, Mass.

PARENTS

17 NAME OF FATHER Albert Vitello Jr.

18 BIRTHPLACE OF FATHER (City) Revere (State or country) Mass.

19 MAIDEN NAME OF MOTHER Harriet Littlefield

20 BIRTHPLACE OF MOTHER (City) (State or country) Maine

21 Informant Albert Vitello (father)
(Address) 310 Princeton St., East Boston, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Hirsmann
(Signature of Agent of Board of Health or other)

Health Officer (Official Designation)
9/4/62 (Date of Issue of Permit)

FM R-301A

INSTRUCTIONS FOR CERTIFICATE

giving OF DEATH

do not enter more than one line for each (b) and (c)

does not mean cause of dying, as heart failure, shock, etc. It means disease, or complication which caused death

Conditions contributing to death but not related to the terminal disease condition given

Chapter 137, of 1954, requires persons to print or type the cause or causes of death on certificates, and Chapter 48, Acts of requires Physicians to print or type their signature.

50-11-59-926662

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R-301A

STRUCTIONS
OR
CERTIFICATE

Surviving
OF DEATH

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Chapter 137,
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The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 166

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. 142 Pleasant St (Winthrop Convalescent Home) St. {(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Chester B. Chapman (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
{(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence, No. 59 Pebble Ave St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..years..months 20 days. In place of residence 35 years..months..days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 11, 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY. That I attended deceased from Aug 5, 1958, to September 11, 1962.
I last saw him alive on September 11, 1962, death is said to have occurred on the date stated above, at 11:40 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) ACUTE MYOCARDIAL INSUFFICIENCY — 2 DAYS
Due To
(b) ARTERIOSCLEROTIC HEART DISEASE INSUFFICIENCY — 4 YRS
Due To
(c) ARTERIOSCLEROSIS — 9 YRS

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Dorothy Cheney Appleton, M. D.
DOROTHY CHENEY APPLETON M.D.
(PRINT OR TYPE SIGNATURE)
(Address) 197 Woodside Ave Winthrop, Mass Date Sept 12 1962

6 Canton Cemetery Canton, Mass
Place of Burial or Cremation (City or Town)
DATE OF BURIAL September 14 1962

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
ADDRESS Winthrop, Mass

Received and filed SEP 13 ~~1962~~ 9/13/1962
John A Clark
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Married

10a If married, widowed, or divorced, HUSBAND of Sadie G. Wright
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 79 Years..Months..Days — If under 24 hours ..Hours..Minutes

13 Usual Occupation: Retired Salesman
(Kind of work done during most of working life)

14 Industry or Business: Drug Supplies

15 Social Security No.

16 BIRTHPLACE (City) Needham, Mass
(State or country)

PARENTS

17 NAME OF FATHER Frederick Chapman

18 BIRTHPLACE OF FATHER (City) Canton
(State or country) Mass

19 MAIDEN NAME OF MOTHER Emma Crowell

20 BIRTHPLACE OF MOTHER (City) Needham
(State or country) Mass

21 Informant Sadie G. Chapman
(Address) 59 Pebble Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Ralph E. Sorenson
(Signature of Agent of Board of Health or other)
Health Officer
(Official Designation)
9/13/62
(Date of Issue of Permit)

028145

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 167

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Maude Dow Cole (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 49 Bates Ave St. Winthrop Mass (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death ....years....months 7 days. In place of residence 2 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept (Month) 11 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1959, to Sept 11, 1962

I last saw he alive on Sept 11, 1962, death is said to have occurred on the date stated above, at 2.40 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Cerebral Embolus	1 week
Due To (b) Rheumatic Heart Disease	40 yrs
Due To (c) Atrial Fibrillation	5 yrs.
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? No

What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Charles Liberman, M. D.

CHARLES LIBERMAN M.D.
(PRINT OR TYPE SIGNATURE)

(Address) WINTHROP, MASS Date 9/11/1962

6 Winthrop, Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept. 13 1962

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop, Mass

Received and filed SEP 12 1962 19....

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Widow

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE Benjamin Cole
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 77 Years 11 Months 1 Days — If under 24 hours ....Hours....Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No. 048-18-3866

16 BIRTHPLACE (City) Albany
(State or country) Vermont

PARENTS

17 NAME OF FATHER James Dow

18 BIRTHPLACE OF FATHER (City)
(State or country) Vermont

19 MAIDEN NAME OF MOTHER Ellen Hayden

20 BIRTHPLACE OF MOTHER (City)
(State or country) Vermont

21 Informant Margaret Brogan
(Address) 49 Bates Ave. Winthrop, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph C. Lerrauno
(Signature of Agent of Board of Health or other)

Health Officer 9/12/62
(Official Designation) (Date of Issue of Permit)

R-301A

RUCTIONS FOR CERTIFICATE

giving OF DEATH

not enter than one for each (b) and (c)

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ons, if any, gave rise to cause (a), the under- cause last.

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Chapter 137, 954, requires ns to print or e cause or of death on ctificates, and 48, Acts of quires Physi- print or type der signature.

011-59-926662

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FI R-301

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 168

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) no

2 FULL NAME Anna B. Queenan
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 47 Loring Rd. St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months....7....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept. (Month) 15, (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 19 52, to Sept. 15 1962
I last saw he alive on Sept. 15 19 62, death is said to have occurred on the date stated above, at 11.15p m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Cancer, Peritoneal — INTERVAL BETWEEN ONSET AND DEATH 5 mos.
Due To (b)
Due To (c)

OTHER SIGNIFICANT CONDITIONS none

Was autopsy performed? no
What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify no

(Signed) Charles Liberman M. D.
Charles Liberman (Print or Type Name)
(Address) Winthrop, Mass. Date 9/15 19 62

6 Place of Burial or Cremation St. Joseph's Purlington, Vermont (City or Town)
DATE OF BURIAL Sept 19 19 62

7 NAME OF FUNERAL DIRECTOR Frederick J. Magrath
ADDRESS ~~525 Chelsea St. E. Boston~~

Received and filed SEP 18 1962 19.....
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 CITIZEN OF U.S.	11 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN
female	white	YES X NO ☐	MARRIED X

11a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Alfred H. Queenan
(Husband's name in full)

12 DATE OF BIRTH

13 AGE 69 Years.....Months.....Days — If under 24 hours .....Hours.....Minutes

14 Usual Occupation: housework Housework
(Kind of work done during most of working life)

15 Industry or Business: own home

16 Social Security No. .....

17 BIRTHPLACE (City) Burlington (State or country) Vermont

PARENTS
18 NAME OF FATHER John Purns
19 BIRTHPLACE OF FATHER (City) Purlington (State or country) Vermont
20 MAIDEN NAME OF MOTHER Mary A, Purcell
21 BIRTHPLACE OF MOTHER (City) Virgennes (State or country) Vermont

22 Informant Alfred H. Queenan
(Address) 47 Loring Rd. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Ralph C. Tirrell
(Signature of Agent of Board of Health or other)
Health Officer 9/18/62
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

DRM R-301

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2-932382

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 169

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Winthrop Com. Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Rebecca Liberman (widowed)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
Rebecca Schneider.

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 238 SHORE DRIVE St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death — years 3 months — days. In place of residence 48 years — months — days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept. (Month) 23 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec., 1935, to Sept. 23, 1962
I last saw he alive on Sept. 23, 1962, death is said to have occurred on the date stated above, at 12:40 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH 5 yrs.
Due To (b)
Due To (c)
OTHER SIGNIFICANT CONDITIONS None.

Was autopsy performed? No.
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS. Date 9/23/1962

Place of Burial or Cremation Forest Dale Cem. Winthrop (City or Town)
DATE OF BURIAL Sept 24 1962

7 NAME OF FUNERAL DIRECTOR Foy Funeral Dir. Inc.
ADDRESS Chelsea

Received and filed SEP 24 1962 19
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 ~~SINGLE~~ ~~MARRIED~~ WIDOWED ~~DIVORCED~~ ~~UNKNOWN~~ (write the word) Widowed

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Max Liberman
(Husband's name in full)

12 AGE 87 Years — Months — Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most working life)

14 Industry or Business: Own home

15 Social Security No. None

16 BIRTHPLACE (City) Russia
(State or country)

PARENTS
17 NAME OF FATHER Oscar Schneider
18 BIRTHPLACE OF FATHER (City) Russia
(State or country)
19 MAIDEN NAME OF MOTHER (C.B.Z.)
20 BIRTHPLACE OF MOTHER (City) Russia
(State or country)

21 Informant Dr. Charles Liberman
(Address)
238 Shore Drive Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Walter E. Sullivan
(Signature of Agent of Board of Health or other)
Health Officer (Official Designation) 9/24/62 (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FRM R-301

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 170

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Michael Rush
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 538 Shirley St Winthrop Mass St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months 1 days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept. (Month) 23 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept 22, 1962, to Sept 23, 1962
I last saw him alive on Sept 23, 1962, death is said to have occurred on the date stated above, at 6 51 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 1 days

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed?
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) William E Kenney, M. D.
William E Kenney
(Print or Type Name)
(Address) 190 Winthrop St Winthrop Date 9/24/62 19

6 Place of Burial or Cremation Winthrop (City or Town)
DATE OF BURIAL Sept 25 1962

7 NAME OF FUNERAL DIRECTOR Ernest P Caggiano
ADDRESS 147 Winthrop St Winthrop

Received and filed SEP 24 1962 19
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word): Single

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE.....Years.....Months 1 Days | If under 24 hours .....Hours.....Minutes

13 Usual Occupation: ✓
(Kind of work done during most working life)

14 Industry or Business: ✓

15 Social Security No.

16 BIRTHPLACE (City) Winthrop
(State or country) Mass

PARENTS

17 NAME OF FATHER John Rush

18 BIRTHPLACE OF FATHER (City) Boston
(State or country) Mass

19 MAIDEN NAME OF MOTHER Jacqueline Reilly

20 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Mass

21 Informant John Rush
(Address) 538 Shirley St Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Ralph E Stevens
(Signature of Agent of Board of Health or other)
Health Officer
(Official Designation) (Date of Issue of Permit) 9/24/62

2-2-932382

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 171

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. 265 River Road St. {(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT
{(Was deceased a U. S. War Veteran, if so specify WAR) NO

2 FULL NAME Joseph F. Rebello
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 265 River Road St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 1 years months days. In place of residence 40 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 26, 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from AUG. 10, 1962 to SEPT. 26, 1962
I last saw him alive on SEPT. 26, 1962, death is said to have occurred on the date stated above, at 2 P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) CARDIAC FAILURE	1 MO.
Due To (b) CHRONIC MYOCARDITIS	1 MO
Due To (c)	
OTHER SIGNIFICANT CONDITIONS CARCINOMA OF LUNG	2 MO
INANITION + PROSTATECTOMY	

Was autopsy performed? NO
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signed) G. M. CAPLAN, M. D
(PRINT OR TYPE SIGNATURE)
(Address) 186 PRINCETON ST EAST BOSTON SEPT. 26, 1962

6 Winthrop Cemetery Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL September 29 1962

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed SEP 28 1962 19
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Widowed

10a If married, widowed, or divorced
HUSBAND of Marion V. DeCosta
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 75 Years Months Days | If under 24 hours Hours Minutes

13 Usual Occupation: Retired Telephone Worker
(Kind of work done during most of working life)

14 Industry or Business: N.E. Tel & Tel Co.

15 Social Security No. 011-07-7051

16 BIRTHPLACE (City) Boston
(State or country) Mass

PARENTS
17 NAME OF FATHER Manuel Rebello
18 BIRTHPLACE OF FATHER (City)
(State or country) Azores
19 MAIDEN NAME OF MOTHER Mary Pimentel
20 BIRTHPLACE OF MOTHER (City)
(State or country) Azores

21 Informant Marion Lynch
(Address) 265 River Road Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Ralph E. Sorenson
(Signature of Agent of Board of Health or other)
Health Officer 9/28/62
(Official Designation) (Date of Issue of Permit)

T VIA

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

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RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia) and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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31-930213

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 172

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Mounts Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

2 FULL NAME Charles (First Name) Bell (Middle Name) Bell (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 279 Chestnut St. Chelsea
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months 31 days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept. 26 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from JAN. 1, 1962, to Sept. 26, 1962
I last saw him alive on Sept. 26, 1962, death is said to have occurred on the date stated above, at 5.15 m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) CARCINOMA COLON
Due To
(b) CARCINOMATOSIS
Due To
(c)
OTHER SIGNIFICANT CONDITIONS HOME

INTERVAL BETWEEN ONSET AND DEATH
1 yr

Was autopsy performed? No
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) MORRIS CLAYMAN, M.D.
(Print or Type Name)
(Address) 198 CHESTNUT ST CHELSEA MASS. Date SEPT 26 1962

6 Agudas Cholom Everet
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Sept 27 1962

7 NAME OF FUNERAL DIRECTOR Joy Funeral Service
ADDRESS Chelsea

Received and filed SEP 27 1962 19.....
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 CITIZEN OF U.S.: YES ☑ NO ☐
11 ~~SINGLE~~ ~~MARRIED~~ WIDOWED ☑ ~~DIVORCED~~ UNKNOWN ☐

11a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Jennie (C. B.Z.)
(Husband's name in full)

12 DATE OF BIRTH

13 AGE 78 Years — Months — Days
If under 24 hours .....Hours.....Minutes

14 Usual Occupation: Dealer
(Kind of work done during most of working life)

15 Industry or Business: Retail Shoe

16 Social Security No. None-18-7987

17 BIRTHPLACE (City) (State or country) Russia

PARENTS
18 NAME OF FATHER Nathan Bell
19 BIRTHPLACE OF FATHER (City) (State or country) Russia
20 MAIDEN NAME OF MOTHER C.B.Z.
21 BIRTHPLACE OF MOTHER (City) (State or country) Russia

22 Informant Mrs Celia Silver
(Address) 130 Shurtleff St Chelsea

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Ralph C. Lucciano
(Signature of Agent of Board of Health or other)
Health Officer 9/27/62
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

ORM R-302

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — MARGIN RESERVED FOR BINDING — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Medford
(City or Town making this return)

Registered No. 173

1 PLACE OF DEATH
Middlesex (County)
Medford (City or Town)
No. 220 Forest St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Walter J.H endrick
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR, no

(a) Residence. No. 144 Circuit Rd. St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 2 years 6 months days. In place of residence 1 years 1 months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September (Month) 27 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan. 1m, 1958, to Sept 27, 1962, I last saw h alive on Aug 20, 1962, death is said to have occurred on the date stated above, at 3.30P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Cerebral Hemorrhage	hrs
Due To (b) Gen. Arteriosclerosis	yrs
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Senility Parkinson's Sundrome	yrs

Was autopsy performed? no
What test confirmed diagnosis? none

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) Dominic Thomas Staffier, M. D.
(Address) 21 Breed St. E. Boston Date Sept 27 1962

6 Place of Burial or Cremation Winthrop (City or Town) Winthrop
DATE OF BURIAL Oct 1, 1962

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.
ADDRESS 917 Bennington St. E. Boston

Received and filed OCT 5 - 1962
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: male
9 COLOR: white
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): widowed

11 If married, widowed, or divorced
HUSBAND of Josephine V. Hayes
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 86 Years 1 Months 26 Days — If under 24 hours Hours Minutes

13 Usual Occupation: Attorney-retired
(Kind of work done during most working life)

14 Industry or Business: Legal

15 Social Security No. -

16 BIRTHPLACE (City) Boston
(State or country) Mass.

PARENTS

17 NAME OF FATHER Jarius S. H endrick

18 BIRTHPLACE OF FATHER (City)
(State or country) Vermont

19 MAIDEN NAME OF MOTHER Jane O' Brien

20 BIRTHPLACE OF MOTHER (City)
(State or country) Ireland

21 Informant Helen McGinn, Niece
(Address)
52 Gladstone St., E. Boston

A TRUE COPY
ATTEST: Hugh F. Lyons
(Registrar of City or Town where death occurred)
DATE FILED Sept 27, 1962

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

MR-305

WHITE PLANET, WITH ONLAPPING BLACK ARCS ON SEA, AND ON BLACK CIRCLE, RIBBON

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-3-61-930213

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Danvers (City or town making return)

Registered No. 174

1 PLACE OF DEATH — Essex (County) — Danvers (City or Town)

No. Danvers State Hospital, Hathorne St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Joseph G. Crafts (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 56 Court Road St. Winthrop, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years 8 months 5 days. In place of residence ....years ....months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept. 28, 1962 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Atalectasis of lung pulmonary emphysema on D. L. less 24 hrs.

5 Accident, suicide, or homicide (specify) ....

Date and hour of injury ....19....

If accidental, was injury causally related to the death? ....

Where did Injury occur? .... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? .... (Specify type of place)

Manner of Injury .... (How did injury occur?)

Nature of Injury ....

While at work? .... Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? ....

If so, specify ....

(Signed) Ralph E. Foss, M. D.

(Address) Peabody, Mass. Date 9-28-19 62

7 Blue Hills Cemetery, Mattapan — Place of Burial or Cremation. (City or Town)

DATE OF BURIAL Oct. 1, 19 62

8 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc

ADDRESS E. Boston, Mass.

Received and filed OCT 8 - 1962 19....

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 CITIZEN OF U.S.	12 SINGLE ☐ MARRIED ☒ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐
male	white	YES ☐ NO ☐	

12a If married, widowed, or divorced HUSBAND of .... (Give maiden name of wife in full)

(or) WIFE of .... (Husband's name in full)

13 DATE OF BIRTH Sept. 7, 1895

14 AGE 67 Years 0 Months 21 Days — If under 24 hours ....Hours ....Minutes

15 Usual Occupation: Bank Guard (Kind of work done during most of working life)

16 Industry or Business: ....

17 Social Security No. 012-16-7333

18 BIRTHPLACE (City) Boston (State or country) Mass.

PARENTS

19 NAME OF FATHER George Crafts

20 BIRTHPLACE OF FATHER (City) .... (State or country) Germany

21 MAIDEN NAME OF MOTHER Ann Lahey

22 BIRTHPLACE OF MOTHER (City) .... (State or country) Ireland

23 Informant Mary E. Sheehan (Address) Hathorne, Mass.

A TRUE COPY. ATTEST: Daniel J. Toomey (Registrar of City or Town where death occurred)

DATE FILED 10/1/ 19 62

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

R-301

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1-62

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

175

OUT - OF - TOWN

To be filed for burial permit with Board of Health or its Agent.

Registered No. 189[illegible]

PLACE OF DEATH

1 SUFFOLK (County)

BOSTON (City or Town)

No. Lemuel Shattuck Hospital St. {(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME MARY (First Name) CUCINOTTA (Middle Name) (Last Name) (If deceased is a married, widowed or divorced woman, give also maiden name.)

{(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Residence. No. 39 Groveland Ave., WINTHROP St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months 40 days. In place of residence ....years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August (Month) 22 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 13, 1962, to August 22, 1962

I last saw he alive on August 22, 1962, death is said to have occurred on the date stated above, at 6.30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) SHOCK.

Due To (b) INTERNAL HEMORRHAGE

Due To (c) Acute peptic ulcer

OTHER SIGNIFICANT CONDITIONS PEMPHIGUS VULGARIS
Pemphigus Vulgaris

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? yes

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? ....
If so, specify ....

(Signed) Willy N. Pachas, M. D.

WILLY N. PACHAS (Print or Type Name)

(Address) Lemuel Shattuck Hosp. Date Aug. 28 1962

6 HOLY CROSS CEMETERY MALDEN
Place of Burial or Cremation (City or Town)

DATE OF BURIAL ~~[illegible]~~ AUG. 25 1962

7 NAME OF FUNERAL DIRECTOR PENNACCHIO + SON

ADDRESS 59 So. MARGIN ST. BOSTON

Received and filed AUG 28 1962 19....

Charles H. Mackie

PERSONAL AND STATISTICAL PARTICULARS

8 SEX F

9 COLOR W

10 CITIZEN OF U.S. YES ✓ ~~NO~~

11 SINGLE ☐ MARRIED ☐ WIDOWED ☑ DIVORCED ☐ UNKNOWN ☐

11a If married, widowed, or divorced
HUSBAND of ....
(Give maiden name of wife in full)
(or) WIFE of FRANCESCO CUCINOTTA
(Husband's name in full)

12 DATE OF BIRTH

13 AGE 75 Years....Months....Days

If under 24 hours ....Hours....Minutes

14 Usual Occupation: AT HOME
(Kind of work done during most of working life)

15 Industry or Business: ....

16 Social Security No. NONE

17 BIRTHPLACE (City) (State or country) ITALY

PARENTS

18 NAME OF FATHER Francesco Auditore

19 BIRTHPLACE OF FATHER (City) (State or country) ITALY

20 MAIDEN NAME OF MOTHER Rosaria Barbera

21 BIRTHPLACE OF MOTHER (City) (State or country) ITALY

22 Informant Sally Mae Dougall
(Address) 14 Marion St. East Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

R. S. Forman
(Signature of Agent of Board of Health or other)

B/2632 8/24/62

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

FCIM R-301

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Agent.

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

176

OUT - OF - TOWN

(City or Town making this return)

Registered No. 08158

1 PLACE OF DEATH: County: Suffolk
City or Town: Boston 20
No. New England Baptist Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: Mr Angelo A. Casamento
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT: (Was deceased a U. S. War Veteran, if so specify WAR) YES WW II

Voting 25 Quincy Ave

(a) Residence. No. 80 Cliff Avenue St. Winthrop, Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months 26 days. In place of residence.....years 3 months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: August (Month) 27 (Day) 1962 (Year)

4 I HEREBY CERTIFY That I attended deceased from August 1, 1962 to August 27, 1962
I last saw him alive on August 26, 1962, death is said to have occurred on the date stated above, at 3.50 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) HEPATIC FAILURE
Due To (b) CARCINOMA OF PANCREAS
Due To (c) WITH METASTASES
OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH: One month

Was autopsy performed? .....
What test confirmed diagnosis? Laparotomy

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....

(Signature) Sowhey Park, M. D.
SOWHEY PARK
(Print or Type Name)
(Address) 605 COMM. AVE. Date 8-27 1962

6 WINTHROP, WINTHROP
Place of Burial or Cremation (City or Town)
DATE OF BURIAL AUG 30 1962

7 NAME OF FUNERAL DIRECTOR MAURICE W. KIRBY
ADDRESS 210 WINTHROP ST. WINTHROP

Received and filed AUG 30 1962 19.....
Charles H. Mackie
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: M
9 COLOR: W
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): married

11 If married, widowed, or divorced
HUSBAND of ~~MARY~~ FLAVIA PINO
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 AGE 54 Years.....Months.....Days
If under 24 hours .....Hours.....Minutes

13 Usual Occupation: ROOFER
(Kind of work done during most working life)

14 Industry or Business: ROOFING

15 Social Security No. 079103281

16 BIRTHPLACE (City) (State or country): NEW YORK

PARENTS
17 NAME OF FATHER: DOMENTO CASAMENTO
18 BIRTHPLACE OF FATHER (City) (State or country): ITALY
19 MAIDEN NAME OF MOTHER: MARIA SABOTO
20 BIRTHPLACE OF MOTHER (City) (State or country): ITALY

21 Informant (Address): FABIA CASAMENTO
80 CLIFF AVE. WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
D. J. McDonald
(Signature of Agent of Board of Health or other)
B 12714 8/29/62
(Official Designation) (Date of Issue of Permit)

A TRUE COPY, ATTEST:

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

177

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT - OF - TOWN

To be filed for burial permit with Board of Health or its Agent.

Registered No. 08916

PLACE OF DEATH

1 SUFFOLK (County)

BOSTON (City or Town)

Massachusetts General Hospital PHILLIPS HOUSE

No. ..... St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Mr. Harold B Stewart
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) WW. I

(a) Residence. No. #48 Beacon St., Winthrop, Mass. St. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 61 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 13th, 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That we attended deceased from Sept. 5, 1962, to Sept. 13, 1962, and we last saw him alive on Sept. 13, 1962, death is said to have occurred on the date stated above, at 12:15a m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Tension Pneumothorax — INTERVAL BETWEEN ONSET AND DEATH 15 days

Due To (b) Chronic Bronchitis and Emphysema — 8 yrs.

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) C. L. Clay, M. D.
Charles L. Clay, M.D.
(PRINT OR TYPE SIGNATURE)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date ..... 19 .....

6 Place of Burial or Cremation Winthrop Cem. Winthrop Mass.
(City or Town)

DATE OF BURIAL Sept. 15 1962

7 NAME OF FUNERAL DIRECTOR William T. McDonald

ADDRESS 17 Yale Ave, Wakefield

Received and filed SEP 14 1962 19 .....
Charles F. Mack
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male

9 COLOR White

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Married

10a If married, widowed, or divorced HUSBAND of Dorothy R. Keegan
(Give maiden name of wife in full)

(or) WIFE of .....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 69 Years 5 Months 7 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Retired Carpenters Supervisor
(Kind of work done during most of working life)

14 Industry or Business: Chelsea Naval Hospital

15 Social Security No. 029-07-5075

16 BIRTHPLACE (City) Montague P.E.I.
(State or country) Canada

PARENTS

17 NAME OF FATHER Benjamin F. Stewart

18 BIRTHPLACE OF FATHER (City) Brudnell, P.E.I.
(State or country) Canada

19 MAIDEN NAME OF MOTHER Lilly D. Johnstone

20 BIRTHPLACE OF MOTHER (City) Montague, P.E.I.
(State or country) Canada

21 Informant Mrs. Dorothy R. Stewart
(Address) 48 Beacon St. Winthrop, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

J. Donato
(Signature of Agent of Board of Health or other)

12884 (Official Designation) 9-13-62 (Date of Issue of Permit)

R-301A

INSTRUCTIONS FOR CERTIFICATE

I giving SE OF DEATH

Do not enter more than one cause for each (a) (b) and (c)

...es not mean ...e: of dying, ...heart failure, ...etc. It means ...se, or compli- ...which caused

...ons, if any, ...have rise to ...e cause (a), ...the under- ...cause last.

...ons contrib- ...death but not ...the terminal ...ndition given

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...ot - Chapter 127, ...1954, requires ...ians to print or ...he cause or ...e of death on ...certificate and ...Acts of ...requires Physi- ...print or type ...der signature.

...Director ...use only

...AK, Inc.

1962

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

MR-301A

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The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 178

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Edna (MacMullen) Lorance (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 180 Winthrop St. (Usual place of abode) St. (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 3 days. In place of residence 40 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct. 2 1962 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1962, to Oct. 2, 1962

I last saw he alive on Oct. 1, 1962, death is said to have occurred on the date stated above, at 4:55 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Cerebro Vascular hemorrhage	10 min
Due To (b) arteriosclerosis generalized	yrs.
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) Joseph Gregorio, M. D.
(PRINT OR TYPE SIGNATURE) Joseph GREGORIO

(Address) 194 Washington St. Date 10/2 1962

6 Puritan Lawn Cemetery Peabody, Mass
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Oct. 4 1962

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds
ADDRESS Winthrop, Mass

Received and filed OCT 3 - 1962 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female

9 COLOR White

10 SINGLE, MARRIED, WIDOWED, or DIVORCED (write the word) Married

10a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Joseph F Lorance (Give maiden name of wife in full) (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 65 Years 2 Months 21 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No. 013-20-1397

16 BIRTHPLACE (City) Boston (State or country) Mass.

PARENTS

17 NAME OF FATHER Edwin MacMullen

18 BIRTHPLACE OF FATHER (City) Boston (State or country) Mass

19 MAIDEN NAME OF MOTHER Unable to obtain

20 BIRTHPLACE OF MOTHER (City) Portland (State or country) Maine

21 Informant Joseph F Lorance
(Address) 180 Winthrop St. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Simonson
(Signature of Agent of Board of Health or other) (HS)

Health Officer Oct. 3, 1962
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FIRM R-301

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 179

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Eva M. Petitpas (Fougere)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 33 Neptune Rd. E. Boston Mass. St. East Boston
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months 1 days. In place of residence 18 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct. (Month) 2 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept. 24, 1962, to Oct. 2, 1962
I last saw her alive on Oct. 2, 1962, death is said to have occurred on the date stated above, at 7:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) CEREBRAL HEMMORRHAGE RIGHT	24 HRS
Due To (b) ARTERIOSCLEROTIC + HYPERTENSIVE HEART DIS.	2 YRS
Due To (c) GENERALIZED ARTERIOSCLEROSIS	3 YRS
OTHER SIGNIFICANT CONDITIONS NONE	

Was autopsy performed? No
What test confirmed diagnosis? Clinical + LAB.

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) M. Traunstein Jr. M. D.
M. TRAUNSTEIN, JR. M.D.
(Print or Type Name)
(Address) 73 BARTLETT RD WINTHROP Date 10/2 1962

6 Holy Cross Cemetery, Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 5th 1962

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.

ADDRESS 917 Bennington St., E. Boston

Received and filed OCT 3 - 1962 19....

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word)
Female	White	Married

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of James H. Petipas
(Husband's name in full)

12 AGE 58 Years 9 Months 26 Days | If under 24 hours ....Hours....Minutes

13 Usual Occupation: Housewife
(Kind of work done during most working life)

14 Industry or Business: At home

15 Social Security No. 023-16-9884

16 BIRTHPLACE (City) Cape Breton
(State or country) Nova Scotia

PARENTS

17 NAME OF FATHER Daniel Fougere

18 BIRTHPLACE OF FATHER (City) Cape Breton
(State or country) Nova Scotia

19 MAIDEN NAME OF MOTHER Philomena Bennett

20 BIRTHPLACE OF MOTHER (City) Cape Breton
(State or country) Nova Scotia

21 Informant Mr. James H. Petipas-hus.
(Address) 33 Neptune Road, East Boston, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph J. Sequanes
(Signature of Agent of Board of Health or other)

Health Officer 10/3/62
(Official Designation) (Date of Issue of Permit)

2-932382

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

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RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-302

THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Danvers
(City or Town making this return)

Registered No. 180

1 PLACE OF DEATH
Essex (County)
Danvers (City or Town)
No. Danvers State Hospital St. Hathorne {(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Maude B. Tewksbury
(If deceased is a married, widowed or divorced woman, give also maiden name.)
{(Was deceased a U. S. War Veteran, if so specify WAR, ---

(a) Residence. No. 98 Bellevue Ave. St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 16 years 4 months 14 days. In place of residence ... years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 5, 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from April 10, 50 to Oct. 5, 62, 19..., I last saw him alive on Oct. 5, 62, 19..., death is said to have occurred on the date stated above, at 4:25a m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Generalized Arteriosclerosis

Due To
(b)

Due To
(c)

OTHER SIGNIFICANT CONDITIONS Bronchopneumonia

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? yes
What test confirmed diagnosis? by autopsy

5 Was disease or injury in any way related to occupation of deceased? ...
If so, specify

(Signed) Andrew Nichols III
Andrew Nichols III, M. D.

(Address) Hathorne, Mass. Date 10/5/ 19 62

6 Place of Burial or Cremation Winthrop Cemetery, Winthrop (City or Town)
DATE OF BURIAL Oct. 6, 19 62

7 NAME OF FUNERAL DIRECTOR Reynolds Funeral Home
ADDRESS Winthrop, Mass.

Received and filed NOV 1 1962 19...

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX female
9 COLOR white
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) single

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 75 Years 6 Months 6 Days
If under 24 hours ... Hours ... Minutes

13 Usual Occupation: none
(Kind of work done during most working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) Winthrop
(State or country) Mass.

PARENTS

17 NAME OF FATHER Herman Douglas Tewksbury

18 BIRTHPLACE OF FATHER (City) Winthrop
(State or country) Mass.

19 MAIDEN NAME OF MOTHER June Garmon

20 BIRTHPLACE OF MOTHER (City) Yarmouth, N.S.,
(State or country) Canada

21 Informant Mary E. Sheehan
(Address) Hathorne, Mass.

A TRUE COPY
ATTEST: Daniel J. Toomey
(Registrar of City or Town where death occurred)

DATE FILED 10/11/ 19 62

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

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50M-3-54-911887

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The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 181

1 PLACE OF DEATH
SUFFOLK (County)
WINTHROP (City or Town)
No. 97 GROVER'S AVE St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Peter Cerbone
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 97 GROVER'S AVE St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 5 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October (Month) 16 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ——, 19—, to ——, 19—

I last saw h— alive on ——, 19—, death is said to have occurred on the date stated above, at 3 P. m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Natural Causes	—
ANTECEDENT CAUSES Due To (b) Presumably Coronary Occlusion	Sudden
Due To (c) Arteriosclerotic Heart Disease	15 years
OTHER SIGNIFICANT CONDITIONS none	—

Major findings: —
Of operations.....

Date of operation — Was autopsy performed? no

What test confirmed diagnosis? Post-mortem judgement

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify Arthur C. Murray, M.D.
(Signed) Arthur C. Murray, M. D.
(Address) Winthrop Board of Health Date 16 Oct 1962

6 HOLY CROSS CEMETERY, MALDEN MASS
Place of Burial or Cremation (City or Town)
DATE OF BURIAL OCT. 19, 1962

7 NAME OF FUNERAL DIRECTOR LAWRENCE BRUNO
ADDRESS 291 REVERE ST. REVERE MASS

Received and filed ..... 19....
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE
9 COLOR OR RACE WHITE
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) MARRIED

10a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of AGATHA ZINO
(Husband's name in full)

11 IF STILLBORN, enter that fact here. —

12 AGE 84 Years 11 Months 22 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: BRICKLAYER
(Kind of work done during most of working life)

14 Industry or Business: CONSTUCTION

15 Social Security No. 034-18-0305A

16 BIRTHPLACE (City) (State or country) ITALY

PARENTS
17 NAME OF FATHER ANTHONY CERBONE
18 BIRTHPLACE OF FATHER (City) (State or country) ITALY
19 MAIDEN NAME OF MOTHER PHILOMENA UNKNOWN
20 BIRTHPLACE OF MOTHER (City) (State or country) ITALY

21 Informant AGATHA CERBONE (wife)
(Address) 97 GROVER'S AVE, WINTHROP MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sullivan
(Signature of Agent of Board of Health or other)
Health Officer 10/15/62
(Official Designation) (Date of Issue of Permit)

✓X

EXTRACTS

FROM THE LAWS OF THE

COMMONWEALTH OF MASSACHUSETTS

GOVERNING THE

RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . .Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. ... — General Laws, Chap. 38, Sec. 6., as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made.
. . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

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3-930213

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 182

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Mayflower Nursing Home, Winthrop St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) NO

2 FULL NAME WILLIAM GILLIS
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No 356 Beach Street St. Revere 51 Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 3 years 7 months days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 16, 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept. 11, 1962 to October 15, 1962
I last saw him alive on October 15, 1962, death is said to have occurred on the date stated above, at 11:0 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Generalized Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 15yrs

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed?
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) John F. Pepi, M. D.
John F. Pepi, M.D.
(Print or Type Name)
(Address) 821 Saratoga St. East Boston, Mass. Date 10-16 1962

6 Place of Burial or Cremation Woodlawn Everett (City or Town)
DATE OF BURIAL Oct. 18 1962

7 NAME OF FUNERAL DIRECTOR J. Lopresti Funeral Ser. Inc.
ADDRESS 262 Pearl St. Malden

Received and filed OCT 19 1962 19
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 CITIZEN OF U.S.	11 SINGLE ☐ MARRIED ☒ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐
Male	White	YES ☒ NO ☐	

11a If married, widowed, or divorced
HUSBAND of Anna Walsh
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 DATE OF BIRTH

13 AGE 87 Years Months Days — If under 24 hours Hours Minutes

14 Usual Occupation: retired.
(Kind of work done during most of working life)

15 Industry or Business:

16 Social Security No. C. N. B. L.

17 BIRTHPLACE (City) Cambridge, Mass
(State or country)

PARENTS

18 NAME OF FATHER Peter Gillis

19 BIRTHPLACE OF FATHER (City) Peter-Gillis
(State or country) Unknown.

20 MAIDEN NAME OF MOTHER Isabella Patterson

21 BIRTHPLACE OF MOTHER (City) Unknown
(State or country)

22 Informant Catherine Gillis
(Address) 18 Reservoir Ave., Revere,

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Ralph E. Vercesani
(Signature of Agent of Board of Health or other)
Health Officer 10/15/62
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R-303

burial permit
of Health
Agent.

information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-9-61-931348

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 183

1 PLACE OF DEATH
SUFFOLK (County)
WINTHROP (City or Town)

En route to Winthrop Community Hospital
No. ..... St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME JACOB (First Name) PASTAN (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 154 Sewall Ave., Winthrop, Mass. St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 30 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October (Month) 17, (Day) 1962 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Occlusive coronary arteriosclerosis and healed myocardial infarction; fracture of right 8th and 9th ribs.

5 Accident, suicide, or homicide (specify) Accident.
Date and hour of injury 10/14 1962
IF ACCIDENTAL, was injury causally related to the death? Yes.
Where did Injury occur? Boston (City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? Market building (Specify type of place)
Manner of Injury Accidental fall downstairs. (How did injury occur?)
Nature of Injury
While at work? ..... Was autopsy performed? Yes.

6 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Michael A. Luongo, M. D.
Michael A. Luongo, M.D. (Print or Type Name)
(Address) Boston Date 10/18 1962

7 Sharon Memorial Park Sharon
Place of Burial, or Cremation. (City or Town)
DATE OF BURIAL October 18 1962

8 NAME OF FUNERAL DIRECTOR Paul R. Levine
ADDRESS 470 Harvard St., Brookline

Received and filed OCT 19 1962 19.....
A TRUE COPY ATTEST: John A. Clark (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male
10 COLOR White
11 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) Married

12 If married, widowed, or divorced
HUSBAND of Miriam M. Ceder (Give maiden name of wife in full)
OR WIFE of ..... (Husband's name in full)

13 DATE OF BIRTH

14 AGE 54 Years.....Months.....Days | If under 24 hours .....Hours .....Minutes

15 Usual Occupation Dealer (Kind of work done during most of working life)

16 Industry or Business Produce

17 Social Security No.

18 BIRTHPLACE (City) Malden (State or country)

PARENTS
19 NAME OF FATHER Hyman Louis Pastan
20 BIRTHPLACE OF FATHER (City) (unknown) (State or country)
21 MAIDEN NAME OF MOTHER Rose (unknown)
22 BIRTHPLACE OF MOTHER (City) (unknown) (State or country)

23 Informant Mrs. Miriam Pastan
(Address) 154 Sewall Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Swanson
(Signature of Agent of Board of Health or other)
Health Officer 10/19/62
(Official Designation) (Date of Issue of Permit)

MEDICAL

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 184

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

Winthrop Convalescent Home No. 142 Pleasant St (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Charles W. Sine (First Name) (Middle Name) (Last Name)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 41 Beachland Ave St. Revere (If nonresident, give city or town and State)

(Usual place of abode)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 18, 1962 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from JAN. 5, 1962, to OCT 18, 1962

I last saw him alive on OCT 15, 1962, death is said to have occurred on the date stated above, at 4 30 P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) CARDIAC DECOMPENSATION	1 yr
Due To (b) GENERLIZED ARTERIOSCLEROSIS	2 yrs
Due To (c) CORONARY HEART DISEASE	1½ yrs
OTHER SIGNIFICANT CONDITIONS CARDIAC FAILURE	3 mos

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Andrew Catino, M. D.

ANDREW CATINO MD (PRINT OR TYPE SIGNATURE)

(Address) 603 BROADWAY REVERE, MASS. Date OCT 19 1962

6 Puritan Lawn Cem. W. Peabody

Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct. 22, 1962

7 NAME OF FUNERAL DIRECTOR Leslie W. Pike

ADDRESS 305 Beach St. Revere

Received and filed OCT 22 1962 (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male

9 COLOR White

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Widowed

10a If married, widowed, or divorced HUSBAND of Frances B Kline (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 88 Years Months Days

If under 24 hours Hours Minutes

13 Usual Occupation: (Gas Station) Owner (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. None

16 BIRTHPLACE (City) Trenton (State or country) New Jersey

PARENTS

17 NAME OF FATHER Arden Sine

18 BIRTHPLACE OF FATHER (City) (State or country) Can not be learned

19 MAIDEN NAME OF MOTHER Can not be learned

20 BIRTHPLACE OF MOTHER (City) (State or country)

21 Informant (Address) Charles W. Sine 41 Beachland Ave Revere

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sorlanno Jr. (Signature of Agent of Board of Health or other)

Health Officer (Official Designation) 10/25/62 (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

CM R-301

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 185

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. 46 Read Street St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME John G. Swansburg (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No. 4 ~~46~~ Read Street St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 32 years ..... months ..... days. In place of residence 32 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October (Month) 18 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from —, 19—, to —, 19—

I last saw h— alive on —, 19....., death is said to have occurred on the date stated above, at 11:00 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Natural Causes

Due To (b) Presumably Coronary Occlusion

Due To (c) Arteriosclerotic Heart Disease

OTHER SIGNIFICANT CONDITIONS none

INTERVAL BETWEEN ONSET AND DEATH — Sudden — 10 yrs.

Was autopsy performed? no

What test confirmed diagnosis? post-mortem judgement

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signature) Arthur C. Murray, M. D.

Arthur C. Murray (Print or Type Name)

(Address) Winthrop Board of Health Date 19 Oct 1962

6 Winthrop Place of Burial or Cremation Winthrop (City or Town)

DATE OF BURIAL Oct 22 1962

7 NAME OF FUNERAL DIRECTOR Ernest P Larggrano

ADDRESS 147 Winthrop St Winthrop

Received and filed OCT 22 1962 19.....

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: male

9 COLOR: white

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): widowed

11 If married, widowed, or divorced HUSBAND of Catherine E Mac Donald (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 AGE 73 Years 4 Months 2 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Expressman (Kind of work done during most working life)

14 Industry or Business: Trucking

15 Social Security No. 015-32-6927

16 BIRTHPLACE (City) Wolburn Mass (State or country) Nova Scotia

PARENTS

17 NAME OF FATHER Thomas J Swansbury

18 BIRTHPLACE OF FATHER (City) (State or country) Nova Scotia

19 MAIDEN NAME OF MOTHER Jane M McKay

20 BIRTHPLACE OF MOTHER (City) (State or country) Nova Scotia

21 Informant Donald Swansburg (Address) 46 Read St Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Ferrante (Signature of Agent of Board of Health or other)

Health Officer (Official Designation) 10/22/62 (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent

Registered No. 186

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town)

No. Bayview Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary E. Jaquith (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 19 Moore St. Winthrop (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ____ years ____ months ____ days. In place of residence ____ years ____ months ____ days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October (Month) 22, (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from December, 1955, to October 22, 1962

I last saw her alive on October 22, 1962, death is said to have occurred on the date stated above, at 8:25a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Arteriosclerotic & Hypertensive heart disease	6 yrs
Due To (b) Generalized arteriosclerosis	8 yrs
~~Due To~~ (c) Other Cerebral arteriosclerosis	1 yr.
OTHER SIGNIFICANT CONDITIONS Blindness	1 yr.

Was autopsy performed? no

What test confirmed diagnosis? Clinical & Laboratory

5 Was disease or injury in any way related to occupation of deceased? NO

If so, specify ____

(Signed) M. Traunstein, Jr., M. D.

(Address) 73 Bartlett Rd. Date Oct. 22, 1962

6 Place of Burial or Cremation: Zion Hill Cemetery (City or Town) Hartford, Conn.

DATE OF BURIAL October 25, 1962

7 NAME OF FUNERAL DIRECTOR Frederic J. Crosby

ADDRESS 867 Beacon St., Boston

Received and filed OCT 23 1962 19____

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Widowed

10a If married, widowed, or divorced HUSBAND of ____ (Give maiden name of wife in full)

(or) WIFE of Perley H. Jaquith (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 82 Years ____ Months ____ Days. If under 24 hours ____ Hours ____ Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No. None

16 BIRTHPLACE (City) (State or country) Norwich, Conn.

PARENTS

17 NAME OF FATHER: William Blackburn

18 BIRTHPLACE OF FATHER (City) (State or country): Scotland

19 MAIDEN NAME OF MOTHER: Unable to learn

20 BIRTHPLACE OF MOTHER (City) (State or country): Scotland

21 Informant: Mr. Edward W. Jaquith

(Address) 262 Willow St. W. Roxbury

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph C. Lerasmo

(Signature of Agent of Board of Health or other)

Health Officer 10/23/62

(Official Designation) (Date of Issue of Permit)

50M-1-58-921876

EXTRACTS

FROM THE LAWS OF THE

COMMONWEALTH OF MASSACHUSETTS

GOVERNING THE

RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . .Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused hy violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. .. — General Laws, Chap. 38, Sec. 6 , as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made.
. . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

FORM R-301

...fi d for burial permit ...th board of Health ... its Agent.

INSTRUCTIONS FOR ...DEAL CERTIFICATE

...RIT OR TYPE ...U:. OR CAUSES ...' DEATH

... not enter ...rre than one ...case for each ...f), (b) and (c)

Th does not mean ...ode of dying, ...h s heart failure, ...hea, etc. It means ...ease, or compli-...io which caused ...t

Conditions, if any, ...h gave rise to ...ate cause (a), ...ting the under-...lyg cause last.

...onditions contrib-...in to death but not ...al to the terminal ...e: condition given ...(.

2-62-932382

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return) .....

Registered No. 187

X

1 PLACE OF DEATH: Suffolk (County); Winthrop (City or Town); No. 94 Sunnyside Ave St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Sebastiano Bordinaro
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 94 Sunnyside Ave St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 8 years ... months ... days. In place of residence 8 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October (Month) 24 (Day), 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ..., 1962, to Oct. 24, 1962
I last saw him alive on 10/22/, 1962, death is said to have occurred on the date stated above, at 11:30 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Cancer of Prostate — INTERVAL BETWEEN ONSET AND DEATH: 5yrs.

Due To (b) ...

Due To (c) ...

OTHER SIGNIFICANT CONDITIONS: Carcinomatosis due Above. — 4yrs.

Was autopsy performed? No
What test confirmed diagnosis Clinical, Pathological.

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify ...

(Signature) Charles Lieberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) Winthrop, Mass. Date 10/25/1962

6 St Michaels Boston Mass
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Oct 27 1962

7 NAME OF FUNERAL DIRECTOR Ernest Pappiano
ADDRESS 149 Winthrop St Winthrop

Received and filed OCT 26 1962 19...
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: Widowed

11 If married, widowed or divorced HUSBAND of Sabastiana Ternullo
(Give maiden name of wife in full)
(or) WIFE of ...
(Husband's name in full)

12 AGE 77 Years 8 Months 10 Days — If under 24 hours ... Hours ... Minutes

13 Usual Occupation: Retired Laborer
(Kind of work done during most working life)

14 Industry or Business: Building Cont.

15 Social Security No. ...

16 BIRTHPLACE (City) (State or country) Italy

PARENTS

17 NAME OF FATHER Joseph Bordinaro

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Antonetta Fruscia

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant Mrs Rose Moratta
(Address) 116 Summit Ave Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Ralph E. Lawrence
(Signature of Agent of Board of Health or other)
Health Officer 10/26/62
(Official Designation) (Date of Issue of Permit)

X

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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INSTRUCTIONS FOR IC. CERTIFICATE

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a

T. C.

2-62-932382

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

(City or Town making this return) .....

STANDARD CERTIFICATE OF DEATH

Registered No. 188

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Clarence Foster Poland
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. 14 Waldemar Ave St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....10 days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October (Month) 25 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 10/15, 1962, to 10/25, 1962
I last saw him alive on 10/25, 1962, death is said to have occurred on the date stated above, at 7:30 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) ACUTE PULMONARY EMBOLUS — 15 MIN

Due To (b) ACUTE PNEUMONITIS — 10 DAYS

Due To (c) .....

OTHER SIGNIFICANT CONDITIONS NONE

Was autopsy performed? No
What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....

(Signature) Myron N King, M. D.
MYRON N KING M.D.
(Print or Type Name)
(Address) 222 PLEASANT ST Date 10/25 1962

6 ~~Forest Glen~~ Laurel Hill Cemetery, Reading Mass
Place of Burial or ~~Cremation~~ (City or Town)
DATE OF BURIAL Oct 29 1962

7 NAME OF FUNERAL DIRECTOR David Malcolm
ADDRESS Reading Mass.

Received and filed Oct 25 1962 19.....
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: M

9 COLOR: White

10 SINGLE (write the word) MARRIED WIDOWED ✓ DIVORCED UNKNOWN

11 If married, widowed, or divorced
HUSBAND of Jessie Nichols
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 AGE 73 Years.....Months.....Days — If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Potter
(Kind of work done during most working life)

14 Industry or Business: Hospital

15 Social Security No. .....

16 BIRTHPLACE (City) ~~[illegible]~~
(State or country) Boston, Mass

PARENTS

17 NAME OF FATHER Clarence Poland

18 BIRTHPLACE OF FATHER (City) Winchendon
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Mary

20 BIRTHPLACE OF MOTHER (City) Winchendon
(State or country) Mass.

21 Informant Hospital Record
(Address)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

[illegible]
(Signature of Agent of Board of Health or other)
Health officer 10/25/62
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 189

1 PLACE OF DEATH
(County) SUFFOLK
(City or Town) WINTHROP
No. 209 SHIRLEY ST. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) NO

2 FULL NAME ROSEANNE (ROSANNA) (THERRIEN) MICHEL
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 209 SHIRLEY ST. St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 5 years ... months ... days. In place of residence 5 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 26 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from ——, 19—, to ——, 19—
I last saw h— alive on ——, 19—, death is said to have occurred on the date stated above, at 5:45 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Natural Causes
Due To (b) Presumably Coronary Occlusion
Due To (c) Arteriosclerotic Heart Disease
OTHER SIGNIFICANT CONDITIONS none

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? no
What test confirmed diagnosis? post mortem judgement

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) Arthur C. Murray M. D.
Arthur C. Murray
(Print or Type Name)
(Address) Winthrop Board of Health Date 26 Oct 1962

6 Place of Burial or Cremation MT CALVERY MANCHESTER N.H.
(City or Town)
DATE OF BURIAL OCT 29 1962

7 NAME OF FUNERAL DIRECTOR MAURICE W. KIRBY
ADDRESS WINTHROP.

Received and filed OCT 31 1962 19
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE
9 COLOR WHITE
10 CITIZEN OF U.S. YES ☒ NO ☐
11 SINGLE ☐ MARRIED ☐ WIDOWED ☒ DIVORCED ☐ UNKNOWN ☐

11a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of EUGENE MICHEL
(Husband's name in full)

12 DATE OF BIRTH FEB 29 1876

13 AGE 86 Years — Months — Days
If under 24 hours ... Hours ... Minutes

14 Usual Occupation: HOME MAKER.
(Kind of work done during most of working life)

15 Industry or Business: HOME.

16 Social Security No.

17 BIRTHPLACE (City) CANADA
(State or country)

PARENTS
18 NAME OF FATHER (UNKNOWN) THERRIEN
19 BIRTHPLACE OF FATHER (City) CANADA
(State or country)
20 MAIDEN NAME OF MOTHER (UNKNOWN) LAFONDE
21 BIRTHPLACE OF MOTHER (City) CANADA
(State or country)

22 Informant (Address) MRS GEO. McDUFFEE 209 SHIRLEY ST WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Ralph E. Lercanni
(Signature of Agent of Board of Health or other)
Health Officer Oct 26 1962
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

1 X

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

ORM R-302

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

M.C.

X

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Danvers
(City or Town making this return)

Registered No. 190

1 PLACE OF DEATH
Essex (County)
Danvers (City or Town)
Danvers State Hospital Hathorne
No. ..... St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary E. Lawson
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR, ...)

(a) Residence. No. 17 Girdlestone Road St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 1 years 4 months 22 days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 27, 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I attended deceased from June 5, 61 to October 27, 62
I last saw h..... alive on October 27, 62 at 1:30a, death is said to have occurred on the date stated above, at ..... m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Acute Pyelonephritis
Due To
(b)
Due To
(c)
OTHER SIGNIFICANT CONDITIONS Uremia

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? No
What test confirmed diagnosis? Clinical & Laboratory

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) Willard M. Hausman
Willard M. Hausman, M. D.
(Address) Hathorne, Mass. Date 10/27/ 62

6 Place of Burial or Cremation Holy Cross Cemetery, Malden (City or Town)
DATE OF BURIAL October 30, 62

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
ADDRESS Winthrop, Mass.

Received and filed NOV 1 1962
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word)
female	white	single

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 AGE 63 Years 8 Months ..... Days
If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Factory Worker
(Kind of work done during most working life)

14 Industry or Business: Greeting Cards

15 Social Security No. 022-03-3982

16 BIRTHPLACE (City) Montreal
(State or country) Canada

PARENTS

17 NAME OF FATHER Edward P. Lawson

18 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

19 MAIDEN NAME OF MOTHER Mary Kerwin

20 BIRTHPLACE OF MOTHER (City) England
(State or country)

21 Informant Mary E. Sheehan
(Address) Hathorne, Mass.

A TRUE COPY
ATTEST: Daniel J. Toomey
(Registrar of City or Town where death occurred)

DATE FILED October 31, 1962

INDEX J.B.

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

R-301A

NSTRUCTIONS FOR IC CERTIFICATE

giving S OF DEATH

do not enter nc than one ate for each a (b) and (c)

does not mean nde of dying, heart failure, etc. It means disse, or complis which caused

tions, if any, gave rise to cause (a), the underlying cause last.

Conditions contrib- death but not to the terminal condition given

:- Chapter 137, 1954, requires ians to print or the cause or of death on certificates, and r 48, Acts of requires Physi- to print or type under signature.

M-6-59-925686

The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 191

PLACE OF DEATH

1 Suffolk (County)
Winthrop (City or Town)
No. Bay View Nursing Home St. {(If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT
{(Was deceased a U. S. War Veteran, if so specify WAR)

2 FULL NAME Euphemia (Hodgson) Hatley
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 41 Washington Ave. St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 2 years months days. In place of residence 35 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH OCT (Month) 29 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from MAR 30, 1950, to OCT 29, 1962
I last saw her alive on OCT 29, 1962, death is said to have occurred on the date stated above, at 1:30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	ACUTE CORONARY OCCLUSION	15 MIN
Due To (b)	ARTERIO-SCLEROTIC HEART DIS	8 YRS
Due To (c)		
OTHER SIGNIFICANT CONDITIONS	NONE	

Was autopsy performed? No
What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased No
If so, specify

(Signed) Myron N. King, M. D.
MYRON N. KING M.D.
(PRINT OR TYPE SIGNATURE)
(Address) 222 PLEASANT ST WINTHROP Date 10/30 1962

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Nov. 1 1962

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds
ADDRESS Winthrop, Mass

Received and filed OCT 31 1962 19
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female
9 COLOR White
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Widow

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Eugene Hatley
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 85 Years 10 Months 14 Days
If under 24 hours Hours Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No. None

16 BIRTHPLACE (City) Shelburne
(State or country) Nova Scotia

PARENTS

17 NAME OF FATHER William Hodgson

18 BIRTHPLACE OF FATHER (City)
(State or country) Nova Scotia

19 MAIDEN NAME OF MOTHER Catherine Locke

20 BIRTHPLACE OF MOTHER (City)
(State or country) Nova Scotia

21 Informant Roberta Barter
(Address) 46 Douglas St. Winthrop, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Joseph E. Fitzgerald
(Signature of Agent of Board of Health or other)
Registrar
(Official Designation) (Date of Issue of Permit) 10/31/62

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

ORM R-302

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

400

Revere
(City or Town making this return)

Registered No. 192

1 PLACE OF DEATH: Suffolk (County); Revere (City or Town)

No. Grover Manor Hospital x (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary L. Lynch a/k/a Minnie Lynch
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR,

(a) Residence. No. 171 Revere St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..years..months 21 days. In place of residence 48 years..months..days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October (Month) 29, (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Oct. 8, 1962, to Oct. 29, 1962
I last saw her alive on Oct. 29, 1962 death is said to have occurred on the date stated above, at 8 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Uremia	48hrs.
Due To (b)	Carcinoma of rectum	3yrs.
Due To (c)		
OTHER SIGNIFICANT CONDITIONS		

Was autopsy performed? no
What test confirmed diagnosis? Clinical signs

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) James F. Burns, M. D.

(Address) 537 Broadway Everett Date 10/30/ 1962

6 St. Joseph Cemetery, Boston
Place of Burial or Cremation (City or Town)
DATE OF BURIAL November 2, 1962

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano
ADDRESS 147 Winthrop St., Winthrop

Received and filed ..... 19..
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Single

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 85 Years 7 Months 2 Days
If under 24 hours ..Hours..Minutes

13 Usual Occupation: Accountant (retired)
(Kind of work done during most working life)

14 Industry or Business: Office Work

15 Social Security No. 028-07-4884

16 BIRTHPLACE (City) New York City
(State or country) New York

PARENTS

17 NAME OF FATHER William J. Lynch

18 BIRTHPLACE OF FATHER (City)
(State or country) Ireland

19 MAIDEN NAME OF MOTHER Mary L. Smith

20 BIRTHPLACE OF MOTHER (City)
(State or country) New York

21 Informant Laura Broussard
(Address) 171 Revere St., Winthrop

A TRUE COPY
ATTEST: [signature]
(Registrar of City or Town where death occurred)

DATE FILED November 1, 1962

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

CRM R-304

SM-6-60-928241

The Commonwealth of Massachusetts
JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

CERTIFICATE OF FETAL DEATH
(STILLBIRTH)

To be filed for burial permit with Board of Health or its Agent.

Registered No. 193

1 PLACE OF DELIVERY
Suffolk (County)
Winthrop (City or Town)
No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 NAME OF FETUS (if given) Ruggiero, ~~Stillborn~~ Male

3 DATE OF DELIVERY 10 (Month) 31 (Day) 1962 (Year)

4 SEX Male M Female Undetermined
5 COLOR (if determined) wh
6 THIS BIRTH (Check one) Single X Twin Triplet
7 IF MULTIPLE BIRTH, BORN: 1st 2nd 3rd

FATHER

8 FULL NAME Nicholas Ruggiero
9 RESIDENCE, NO. 962 Bennington STREET
CITY OR TOWN East Boston STATE Mass
10 COLOR OR RACE W
11 AGE AT TIME OF THIS DELIVERY 34 (Years)
12 PLACE OF BIRTH East Boston (City or Town) Mass (State or country)
13 OCCUPATION Plumber.

MOTHER

14 MAIDEN NAME Adeline Albanese
PRESENT NAME Adeline Ruggiero
15 RESIDENCE, NO. 962 Bennington STREET
CITY OR TOWN Boston STATE Mass
16 COLOR OR RACE W
17 AGE AT TIME OF THIS DELIVERY 34 (Years)
18 PLACE OF BIRTH Boston (City or Town) Mass (State or country)
19 INFORMANT Nicholas Ruggiero

20 PREVIOUS DELIVERIES TO MOTHER (Do not include this fetus) 3
(a) How many children are now living? 3
(b) How many children were born alive but are now dead? none
(c) How many previous fetal deaths of ANY gestation age? none

21 LENGTH OF PREGNANCY 28 3/4 completed weeks
22 WEIGHT OF FETUS Lb. Oz. (or Grams)
23 WHEN DID FETUS DIE? Before Labor ✓ During Labor or Delivery Unknown
24 AUTOPSY Yes No ✓

25 FETAL DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Phocomelia (Fetal Deformities)
Due To (b)
Due To (c)

OTHER SIGNIFICANT CONDITIONS Toxemia of pregnancy

26 Place of Burial or Cremation Woodlawn Everett (City or Town)
DATE OF BURIAL Nov 1 1962

27 NAME OF FUNERAL DIRECTOR Ernest Caggiano
ADDRESS 147 Winthrop St Winthrop

Received and filed NOV 1 1962 19
(Registrar)

A TRUE COPY ATTEST:

I HEREBY CERTIFY that this delivery occurred on the date stated above at 10 a.m., and product of conception was not a live birth.

Signature of Attending Physician or Medical Examiner:
D Thomas Staffier. M.D.
D. Thomas Staffier, MD
(PRINT OR TYPE SIGNATURE)
Address Breed St E.B. Date 10/31 1962

I HEREBY CERTIFY that a satisfactory certificate of fetal death was filed with me BEFORE the burial or transit permit was issued:
Ralph E Fiveash
(Signature of Agent of Board of Health or other)
Health Officer 11/1/62
(Official Designation) (Date of Issue of Permit)

In giving CAUSE OF FETAL DEATH do not enter more than one cause for each of (a), (b) and (c)

Fetal or maternal condition causing fetal death (do not use such terms as stillbirth or prematurity.) Fetal and/or maternal conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

Conditions of fetus or mother which may have contributed to fetal death, but, in so far as is known, were not related to cause given (a).

FETAL DEATH

EXTRACTS OF CERTAIN SECTIONS OF CHAPTER 46 AS AMENDED OR ADDED BY CHAPTER 48. ACTS OF 1960.

*Section 2*A. "Examination of records and returns of illegitimate births, or abnormal sex births, or fetal deaths, . . . shall not be permitted except. . . ".

*Section 9*A. When a child is born dead, after a period of gestation of not less than twenty weeks, and in the fetus there is no attempt at respiration, no action of heart and no movement of voluntary muscle, the physician or officer attending at the birth of such child shall forthwith furnish for registration, at the request of an undertaker or other authorized person or of any member of the family of the deceased, a certificate of fetal death on a form which shall be prepared by the secretary of state as required by section sixteen. Town clerks shall record certificates of fetal death in the town register of deaths in the same manner as a death certificate, but they shall not be required to record such certificates in the town register of births.

Section 12. ". . . No birth record of a child born out of wedlock or of a child of abnormal sex, and no record of fetal death shall so be transmitted to any other city or town."

Section 24. In any statement of births, deaths and fetal deaths printed by a town the name of an illegitimate child or of its parents or of the parents of a child born dead shall not be printed, but the word "illegitimate" or "fetal death" shall be used in place thereof. A town violating this section shall forfeit to the mother of such child not more than one hundred dollars.

R-301A

STRICTIONS
OR
AL CERTIFICATE

Inviving
E OF DEATH

t enter
than one
for each
), b) and (c)

s not mean
of dying,
eart failure,
, etc. It means
or compli-
hich caused

34

ss, if any,
ve rise to
ause (a),
the under-
ause last.

ions contrib-
eath but not
the terminal
ndition given

Chapter 137,
54, requires
to print or
cause or
death on
ificates, and
48, Acts of
uires Physi-
print or type
er signature.

C 3 - 1962

-59-925686

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT - OF - TOWN

To be filed for burial permit with Board of Health or its Agent.

194

Registered No. 09053

1 PLACE OF DEATH
SUFFOLK (County)
BOSTON, MASS (City or Town)
No. MASSACHUSETTS GENERAL HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

2 FULL NAME Angela Maddaloni (DiVita)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 23 Trident Avenue St. Winthrop, Massachusetts
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..years..months 1 days. In place of residence ..years ..months ..days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 14 1962
(Month) (Day) (Year)

I HEREBY CERTIFY That I attended deceased from Sept. 13 1962 to September 14 1962
I last saw her alive on September 14 1962, death is said to have occurred on the date stated above, at 2:20pm

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Cerebral hemorrhage	18hrs
Due To (b) Cerebral arterial Schlerosis	? yrs
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Hypertension	unknown

Was autopsy performed? no
What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) C. C. Clay, M. D.
(PRINT OR TYPE SIGNATURE)
(Address) Date Sept. 14, 62

6 Winthrop Cemetery, Winthrop
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Sept. 18, 1962

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano
ADDRESS 147 Winthrop St., Winthrop

Received and filed SEP 18 1962
Charles A. Mac (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female
9 COLOR White
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Widow

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of John Maddaloni
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 72 Years 10 Months 18 Days
If under 24 hours ..Hours..Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: at home

15 Social Security No. 019-18-0997

16 BIRTHPLACE (City) (State or country) Italy

PARENTS
17 NAME OF FATHER Carmen DiVita
18 BIRTHPLACE OF FATHER (City) (State or country) Italy
19 MAIDEN NAME OF MOTHER Anna Palazzolo
20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant Vincent DiVita
(Address) 56 Park Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
R. J. Rogerson Jr.
(Signature of Agent of Board of Health or other)
12923 9-17-62
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

RECEIVED

DEC 3 1962 AM

ORM R-301

for burial permit
ard of Health
ts Agent.

RUCTIONS
FOR
CERTIFICATE

OR TYPE
OR CAUSES
DEATH

not enter
than one
for each
(b) and (c)

does not mean
le of dying,
heart failure,
etc. It means
se, or compli-
which caused

ions, if any,
gave rise to
cause (a),
the under-
cause last.

litions contrib-
death but not
the terminal
ondition given

120.1
c.81
X70

C 3 - 1962

Director
use only
CK Ink.

2-932382

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

X

OUT - OF - TOWN 195
(City or Town making this return)

Registered No. 09135

PLACE OF DEATH
1 SUFFOLK (County)
BOSTON (City or Town)
No. MASSACHUSETTS GENERAL HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Jessie McLaren M. (MacDonald)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 3 Willis Avenue St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death years 1 months 7 days. In place of residence 8 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September (Month) 17 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from August 13, 1962, to September 17, 1962, and last saw he alive on September 17, 1962 death is said to have occurred on the date stated above, at 10:50 am.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Myocardial Infarct, Acute Posterior	2 wks
Due To (b) Coronary Atherosclerosis and Thrombosis, Rt Branch	2 wks
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Acute Pericarditis	unk

Was autopsy performed? yes
What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) C. L. Clay, M. D.
~~Charles L. Clay, M.D.~~
(Print or Type Name)
(Address) ~~Asst. Dir., Mass. Gen'l. Hosp.~~ Date Sept. 17, 1962

Woodlawn Cemetery, Everett
Place of Burial or Cremation (City or Town)
DATE OF BURIAL September 20th, 1962

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.
ADDRESS 917 Bennington St., E. Boston

Received and filed SEP 21 1962, 19
Charles H. MacNeil (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Alexander McLaren
(Husband's name in full)

12 AGE 80 Years 2 Months 9 Days — If under 24 hours Hours Minutes

13 Usual Occupation: Housewife
(Kind of work done during most working life)

14 Industry or Business: At home

15 Social Security No. None

16 BIRTHPLACE (City) Provincetown
(State or country) Mass.

PARENTS

17 NAME OF FATHER Roderick MacDonald

18 BIRTHPLACE OF FATHER (City) Nova Scotia
(State or country) Canada

19 MAIDEN NAME OF MOTHER Jessie MacDonald)OK)

20 BIRTHPLACE OF MOTHER (City) Nova Scotia
(State or country) Canada

21 Informant Mrs. Jesse Cann-daughter
(Address) 3 Willis Avenue, Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
R Gorman
(Signature of Agent of Board of Health or other)
12971 (Official Designation) 9-19-62 (Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles F. Mackie

City Registrar

R-301A

UCTIONS FOR CERTIFICATE

giving OF DEATH

ot enter than one for each (b) and (c)

es not mean of dying, heart failure, etc. It means e, or campli- which caused

ms, if any, ave rise to cause (a), the under- cause last.

itions contrib- death but not the terminal ndition given

70

Chapter 137, 1954, requires ans to print or the cause of of death on certificates, and r 48, Acts of equires Physi- o print or type nder signatu

3-62

0-928145

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT - OF - TOWN

To be filed for burial permit with Board of Health or its Agent. 196

Registered No. 190132

PLACE OF DEATH

1 SUFFOLK (County)

BOSTON (City or Town)

No. ST. Elizabeth Hosp St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME MRS CATHERINE V. WALSH (Cuddy) (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
Was deceased a U. S. War Veteran, (if so specify WAR) No

(a) Residence. No. 98 Grandview Ave St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months....19....days. In place of residence 7 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 9 (Month) 18 (Day) 62 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to....., 19.....

I last saw he alive on ....., 19....., death is said to have occurred on the date stated above, at 5:30 A.m.

INTERVAL BETWEEN ONSET AND DEATH

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) LYMPHATIC METASTASE T. LUNG

Due To (b) CARCINOMA of BREAST

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) William F. Doyle, M. D
WILLIAM F. DOYLE
(PRINT OR TYPE SIGNATURE)

(Address) ST. ELIZABETHS HOSP Date 9-18- 19 62

6 Old Calvary Cemetery, Boston
Place of Burial or Cremation (City or Town)

DATE OF BURIAL September 21st 19 62

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.

ADDRESS 917 Bennington St., E. Boston

Received and filed SEP 26 1962 Charles F. Mahoney 19
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female

9 COLOR White

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Married

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Thomas J. Walsh
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 58 Years 2 Months 6 Days
If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No. None

16 BIRTHPLACE (City) Boston
(State or country) Mass.

PARENTS

17 NAME OF FATHER William H. Cuddy

18 BIRTHPLACE OF FATHER (City) Boston
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Margaret T. Fitzgerald

20 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Mass.

21 Informant Mr. Thomas J. Walsh-hus.
(Address) 98 Grand View Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

R Gaeman
(Signature of Agent of Board of Health or other)

42970 (Official Designation) 9-19-62 (Date of Issue of Permit)

V.B.V

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT - OF - TOWN 97

To be filed for burial permit with Board of Health or its Agent.

Registered No. 09578

1 PLACE OF DEATH: Suffolk (County); Brighton (City or Town); No. St. Elizabeth's Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: Dallas (First Name) E. (Middle Name) Addison (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT: (Was deceased a U. S. War Veteran, if so specify WAR) WWI

(a) Residence, No. 91 (Usual place of abode) Sargeant St. Winthrop (If nonresident, give city or town and State)

Length of stay: In place of death ... years ... months 15 days. In place of residence 37 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: Sept. (Month) 28 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 9-13, 1962, to 9-28, 1962. I last saw him alive on 9-28, 1962, death is said to have occurred on the date stated above, at 8 12 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bile Peritonitis & Abd. Abscess

INTERVAL BETWEEN ONSET AND DEATH: 8 d.

Due To (b) Common Duct Stone

Due To (c)

OTHER SIGNIFICANT CONDITIONS: Acute + Chronic Pancreatitis, Post Op. Cholecystectomy

Was autopsy performed? YES. Autopsy

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signed) Paul F. Condon M. D.
PAUL F. CONDON M.D.
(PRINT OR TYPE SIGNATURE)

(Address) St. Eliz. Hosp. Date 9.28.62

6 Place of Burial or Cremation: Woodlawn Crematory (City or Town) Everett, Mass

DATE OF BURIAL: Oct. 1 1962

7 NAME OF FUNERAL DIRECTOR: Howard S Reynolds
ADDRESS: Winthrop, Mass

Received and filed OCT 2 1962
Charles H. Mackie (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Married

10a If married, widowed, or divorced HUSBAND of: Amy Ball (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE: 67 Years 11 Months 15 Days. If under 24 hours ... Hours ... Minutes

13 Usual Occupation: Printer (Kind of work done during most of working life)

14 Industry or Business: Publications

15 Social Security No. 010-07-9331

16 BIRTHPLACE (City) (State or country): Chapin Iowa

PARENTS

17 NAME OF FATHER: John Addison

18 BIRTHPLACE OF FATHER (City) (State or country): Unable to obtain

19 MAIDEN NAME OF MOTHER: Dora Dillingham

20 BIRTHPLACE OF MOTHER (City) (State or country): Unable to obtain

21 Informant (Address): Amy Addison 1 Sargent St. Winthrop, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

J. Donato (Signature of Agent of Board of Health or other)

13134 (Official Designation) 10-1-62 (Date of Issue of Permit)

-928145

A TRUE COPY ATTEST:
Charles H. [illegible]
[illegible]

RECEIVED
OFFICE OF TOWN CLERK
WINTHROP, MASS.
DEC 7 1962 PM

ORM R-302

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Waltham (City or Town making this return)

Registered No. 529 198

1 PLACE OF DEATH: Middlesex (County); Waltham (City or Town)

No. 21 Brigham Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: Agnes T. Murphy (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

Nativity Est. 34 ~~28~~ Tafts Avenue Winthrop, Mass

(a) Residence. No. 2 (Usual place of abode) St. 50 (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: September 29, 1962 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from March 16, 1962, to Sept. 29, 1962, and last saw him alive on Sept. 28, 1962, death is said to have occurred on the date stated above, at 10:40P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

	INTERVAL BETWEEN ONSET AND DEATH
(a) Cerebral Thrombosis	
Due To (b) recurrent	2days
Due To (c) Arteriosclerosis generalized	?
OTHER SIGNIFICANT CONDITIONS Cardiomegaly	

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) ....., M. D.

(Address) 634 Moody St. Wal. Date Sept. 29, 62 19....

6 Place of Burial or Cremation: Gold Mary Cemetery (City or Town) Waltham

DATE OF BURIAL October 3, 1962 19....

7 NAME OF FUNERAL DIRECTOR: Bernard E. Mullin

ADDRESS 16 Prospect St. Waltham

Received and filed NOV 5 1962 19....

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Single

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 AGE 82 Years.....Months.....Days. If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Sales Girl (Variety Store)
(Kind of work done during most working life)

14 Industry or Business: Variety Store

15 Social Security No.

16 BIRTHPLACE (City) (State or country): New Foundland, N.B. Canada

PARENTS

17 NAME OF FATHER: Timothy Murphy

18 BIRTHPLACE OF FATHER (City) (State or country): cannot be learned Canada

19 MAIDEN NAME OF MOTHER: cannot be learned

20 BIRTHPLACE OF MOTHER (City) (State or country): " " " " " "

21 Informant (Address): Mary Ellsworth, 59 Mayall Road, Waltham

A TRUE COPY
ATTEST: William J. Lonergan
(Registrar of City or Town where death occurred)

DATE FILED October 4, 1962 19....

M. C.

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

FORM R-301

...ed for burial permit ...Board of Health ...r its Agent.

...STRUCTIONS FOR ...ICAL CERTIFICATE

...RINT OR TYPE ...LE OR CAUSES ...F DEATH

...o not enter ...ore than one ...use for each ...a), (b) and (c)

...This does not mean ...e mode of dying, ...as heart failure, ...nia, etc. It means ...iseases, or compli-...tions which caused ...a.

...Conditions, if any, ...hich gave rise to ...ove cause (a), ...ting the under-...ing cause last.

...Conditions contrib-...ut to death but not ...ed to the terminal ...e condition given ...).

430
80
X70

...m.c.
...C 7 - 1962

...2-62-932382

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT - OF - TOWN

(City or Town making this return) 199

Registered No. 10289

1 PLACE OF DEATH
SUFFOLK (County)
ROXBURY (City or Town)
No. JEWISH MEMORIAL HOSPITAL (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME CLARA GREENBERG
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Residence, No. 18 DOLPHIN AVE. WINTHROP
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years ....months ....6 days. In place of residence 37 years ....months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH OCTOBER (Month) 4 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 9-28, 1962, to 10-4, 1962
I last saw he alive on 10-4, 1962 death is said to have occurred on the date stated above, at 10:P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) ACUTE PULMONARY EDEMA
Due To
(b) ARTERIOSCLEROTIC HEART
Due To
(c) DISEASE

INTERVAL BETWEEN ONSET AND DEATH
Hours
years

OTHER SIGNIFICANT CONDITIONS DIABETES MELLITUS

Was autopsy performed? NO
What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? NO
If so, specify

(Signature) Samuel Hassid, M. D.
SAMUEL HASSID
(Print or Type Name)
(Address) Jerry Mill Hosp. Date 10-4 1962

6 KNIGHTS OF LIBERTY WOBURN
Place of Burial or Cremation (City or Town)
DATE OF BURIAL OCT. 5 1962

7 NAME OF FUNERAL DIRECTOR BENJAMIN BIRNBACH
ADDRESS 1468 BEACON ST. BROOKLINE

Received and filed OCT 9 1962 19..
Charles H. Mackie
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female
9 COLOR White
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) WIDOWED

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of ABRAHAM GREENBERG
(Husband's name in full)

12 AGE 77 Years ....Months ....Days
If under 24 hours ....Hours ....Minutes

13 Usual Occupation HOUSEWIFE
(Kind of work done during most working life)

14 Industry or Business: AT HOME

15 Social Security No.

16 BIRTHPLACE (City) (State or country) RUSSIA

PARENTS
17 NAME OF FATHER CBL
18 BIRTHPLACE OF FATHER (City) (State or country) RUSSIA
19 MAIDEN NAME OF MOTHER CBL
20 BIRTHPLACE OF MOTHER (City) (State or country) RUSSIA

21 Informant HARRY FISHMAN
(Address) 19 BEVERLY RD. WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
J. McMahon
(Signature of Agent of Board of Health or other)
131321 (Official Designation) 10-5-62 (Date of Issue of Permit)

A TRUE COPY ATTEST:

K.V.B.

A TRUE COPY, ATTEST

Charles H. [illegible]

DIRECTOR

DRM R-301

for burial permit
Board of Health
or its Agent.

INSTRUCTIONS
FOR
CATE CERTIFICATE

N OR TYPE
EDR CAUSES
DEATH

Do not enter
more than one
line for each
(b) and (c)

does not mean
time of dying,
a heart failure,
etc. It means
disease, or compli-
which caused

tions, if any,
gave rise to
cause (a),
the under-
cause last.

Conditions contrib-
death but not
to the terminal
condition given

121
52
121

C 7 - 1962

Director
use only
ACK Ink.

-62-932382

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

OUT - OF - TOWN 200

(City or Town making this return)

STANDARD CERTIFICATE OF DEATH

Registered No. 1083[illegible]

1 PLACE OF DEATH: SUFFOLK (County) — BOSTON (City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Isabelle E. Greenlaw (Raymond)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

V. B. Pkg. - 22 Neptune Rd.

(a) Residence. No. 555 Shirley Street St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years ....months ....days. In place of residence 11 years .... months .... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October (Month) 6 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from September 27, 62 to October 6, 1962, and last saw deceased alive on October 6, 1962 death is said to have occurred on the date stated above, at 11:45 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) METASTATIC CARCINOMA

Due (b) CARCINOMA of CERVIX

Due To (c)

OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH: ? MO. / 10 Yrs.

Was autopsy performed? yes

What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased? ....
If so, specify ....

(Signature) C. L. Clay, M. D.

Charles L. Clay, M.D.
(Print or Type Name)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date Oct. 6, 1962

6 Winthrop Cemetery, Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL October 10, 1962

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano

ADDRESS 147 Winthrop St., Winthrop

Received and filed OCT 11 1962, 19....

Charles F. Mackie
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female

9 COLOR: white

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): married

11 If married, widowed, or divorced
HUSBAND of ....
(Give maiden name of wife in full)
(or) WIFE of Arthur W. Greenlaw
(Husband's name in full)

12 AGE 41 Years 2 Months 15 Days — If under 24 hours: ....Hours ....Minutes

13 Usual Occupation: Singer-Pianist
(Kind of work done during most working life)

14 Industry or Business: Entertainment

15 Social Security No. 018-18-5983

16 BIRTHPLACE (City) Malden
(State or country) Massachusetts

PARENTS

17 NAME OF FATHER John J. Raymond

18 BIRTHPLACE OF FATHER (City) Boston
(State or country) Massachusetts

19 MAIDEN NAME OF MOTHER Florence May Greenlaw

20 BIRTHPLACE OF MOTHER (City) ....
(State or country) New Brunswick

21 Informant Arthur W. Greenlaw
(Address) 555 Shirley St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

D. McNamara
(Signature of Agent of Board of Health or other)

B13277 (Official Designation) 10-10-62 (Date of Issue of Permit)

A TRUE COPY ATTEST:

Received 10-8-62

A TRUE COPY. ATTEST:

Charles H. Mackie

City Registrar

R R-301A

NSTRUCTIONS FOR CI CERTIFICATE

I giving SIOF DEATH

Do not enter or than one u for each a (b) and (c)

does not mean me of dying, a heart failure, is etc. It means ise, or complica- which caused

dons, if any, gave rise to e cause (a), in the under- g cause last.

ditions contrib- t death but not the terminal ondition given

M.C.

234

Chapter 387, 1954, requires cians to print or the cause or of death on certificates, and r 48, Acts of requires Physi- o print or type under signature.

7 - 1962

50-928145

Kalman Disler

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT - OF - TOWN

To be filed for burial permit with Board of Health or its Agent.

Registered No. 1095 L

1 PLACE OF DEATH
County: Suffolk
City or Town: Boston
No. Beth Israel Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Kalmen (First Name) H. (Middle Name) Disler (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No. 379 Shirley Street St. Winthrop, Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 15 days. In place of residence 15 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct. (Month) 8 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept 23, 1962, to Oct 8, 1962
I last saw him alive on Oct 8, 1962, death is said to have occurred on the date stated above, at 8:20 A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Cerebro - vascular accident
Due To (b) Arterio sclerotic cerebro-
Due To (c) vascular disease
OTHER SIGNIFICANT CONDITIONS osteoarthritis

INTERVAL BETWEEN ONSET AND DEATH
15 days
yrs.

Was autopsy performed? no
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) Stephen Bulova, M. D
Stephen Bulova
(PRINT OR TYPE SIGNATURE)
(Address) 330 Brookline Ave Boston Date Oct. 8 1962

6 TIFERETH ISRAEL of WINTHROP EVERETT
Place of Burial or Cremation (City or Town)
DATE OF BURIAL OCT. 10 1962

7 NAME OF FUNERAL DIRECTOR Morris W. BREZNIAK
ADDRESS 470 HARVARD ST. BROOKLINE

Received and filed OCT 10 1962 19
Charles H. Mackie
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: MALE
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED, or DIVORCED (write the word): MARRIED

10a If married, widowed, or divorced HUSBAND of LENA ROMM
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 82 Years ..... Months ..... Days
If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: CARPENTER
(Kind of work done during most of working life)

14 Industry or Business: RETIRED

15 Social Security No. UNKNOWN

16 BIRTHPLACE (City) (State or country) RUSSIA

PARENTS

17 NAME OF FATHER UNKNOWN

18 BIRTHPLACE OF FATHER (City) (State or country) RUSSIA

19 MAIDEN NAME OF MOTHER UNKNOWN

20 BIRTHPLACE OF MOTHER (City) (State or country) RUSSIA

21 Informant LENA DISLER
(Address) 379 SHIRLEY ST., WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
D. McManamara
(Signature of Agent of Board of Health or other)
B 13248 (Official Designation)
10-9-62 (Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

RECEIVED

DEC 7 1962 PM

ORM R-302

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Danvers
(City or Town making this return)

Registered No. 202

1 PLACE OF DEATH
Essex (County)
Danvers (City or Town)
No. Danvers State Hospital, Hathorne St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Frank Nigro
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR, ---

(a) Residence. No. 374 Pleasant St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months 29 days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November (Month) 4, (Day) 1962 (Year)

I HEREBY CERTIFY, That I attended deceased from Oct. 5, 1962, to Nov. 4, 1962, I last saw him alive on Nov. 4, 1962, death is said to have occurred on the date stated above, at 7:15p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Arteriosclerotic heart disease

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS Terminal Pneumonia

Was autopsy performed? no
What test confirmed diagnosis? clinical & Laboratory

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify

(Signed) Willard M. Hausman
Willard M. Hausman, M.D., M. D.

(Address) Hathorne, Mass. Date 11-5- 1962

6 Place of Burial or Cremation Winthrop Cemetery, Winthrop (City or Town)
DATE OF BURIAL November 7, 1962

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano
ADDRESS Winthrop, Mass.

Received and filed DEC 3 - 1962 19.....
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: male
9 COLOR: white
10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: widowed

11 If married, widowed, or divorced
HUSBAND of Mary Ann Muntz
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 88 Years 5 Months 26 Days — If under 24 hours ....Hours....Minutes

13 Usual Occupation: None
(Kind of work done during most working life)

14 Industry or Business:

15 Social Security No. Not determined

16 BIRTHPLACE (City) Naples
(State or country) Italy

PARENTS

17 NAME OF FATHER Not Determined

18 BIRTHPLACE OF FATHER (City)
(State or country) Italy

19 MAIDEN NAME OF MOTHER Not Determined

20 BIRTHPLACE OF MOTHER (City)
(State or country) Italy

21 Informant Mary E. Sheehan
(Address) Hathorne, Mass.

A TRUE COPY
ATTEST: [signature]
(Registrar of City or Town where death occurred)

DATE FILED November 7, 1962

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

R-305

The Commonwealth of Massachusetts
JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(City or town making return)

Registered No. 303

1 PLACE OF DEATH

Essex (County)

Danvers (City or Town)

No. Scribner Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Anthony George Silva (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) ---

(a) Residence. No. Corinha Beach St. / Winthrop, Mass. (If not resident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death 1 years ... months ... days. In place of residence 8 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 7, 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Prob. Coronary thrombosis no recent medical attention, sudden death

5 Accident, suicide, or homicide (specify) ...

Date and hour of injury ... 19...

If accidental, was injury causally related to the death? ...

Where did Injury occur? ... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ... (Specify type of place)

Manner of Injury ... (How did injury occur?)

Nature of Injury ...

While at work? ... Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? ...

If so, specify ...

(Signed) Ralph E. Foss, M. D.

(Address) Peabody, Mass. Date 11-8-19 62

7 Place of Burial, or Cremation. Holy Cross Cemetery, Malden (City or Town)

DATE OF BURIAL November 10, 19 62

8 NAME OF FUNERAL DIRECTOR Whlyert Mc Donald, Jr.

ADDRESS 18 Hawthorne Blvd., Salem

Received and filed ... 19...

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: male

10 COLOR: white

11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Widowed

11a If married, widowed, or divorced HUSBAND of Anna May Corinha (Give maiden name of wife in full)

(or) WIFE of ... (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 82 Years ... Months ... Days. If under 24 hours ... Hours ... Minutes

14 Usual Occupation: Carpenter (Kind of work done during most of working life)

15 Industry or Business: Carpenter-City of Winthrop

16 Social Security No. 026-11-8772

17 BIRTHPLACE (City) Beverly (State or country) Mass.

PARENTS

18 NAME OF FATHER Antoine Silva

19 BIRTHPLACE OF FATHER (City) ... (State or country) Portugal

20 MAIDEN NAME OF MOTHER Frances Rock

21 BIRTHPLACE OF MOTHER (City) ... (State or country) Portugal

22 Informant Anthony J. Silva (Son)
(Address) 139 Endicott St., Danv-

A TRUE COPY ATTEST: Daniel J. Toomey
(Registrar of City or Town where death occurred)

DATE FILED Nov. 9. 19 62

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-4-59-925100

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

R-301A

STRUCTIONS FOR A CERTIFICATE

giving EOF DEATH

ot enter or than one for each (b) and (c)

es not mean of dying, heart failure, etc. It means ee, or compli- which caused

ns, if any, have rise to cause (a), the under- cause last.

itions contrib- death but not the terminal ondition given

- Chapter 137, 1954, requires ans to print or he cause or of death on certificates, and r 48, Acts of equires Physi- o print or type nder signature.

30-928145

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 204

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

2 FULL NAME William J. Epps
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. 63 Crest Avenue St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months 15 days. In place of residence 32 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 12, 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan 62, to Nov 12 62
I last saw h. alive on Nov 12 1962, death is said to have occurred on the date stated above, at 1:31 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Myocardial Heart Disease — yrs
Due To (b) arteriosclerosis
Due To (c) generalized — yrs
OTHER SIGNIFICANT CONDITIONS amaurosis bilateral — yrs

Was autopsy performed?
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Joseph Gregoire M. D.
Joseph GREGOIRE
(PRINT OR TYPE SIGNATURE)
(Address) 194 Washington St Date 11/13 1962

6 Old Calvary Cemetery Boston
Place of Burial or Cremation (City or Town)
DATE OF BURIAL 11-15-62 19

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
ADDRESS 79 Atlantic St., Winthrop

Received and filed NOV 14 1962 19
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word): widowed

10a If married, widowed, or divorced
HUSBAND of Mary Agnes Ready
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 90 Years....Months....Days — If under 24 hours ....Hours....Minutes

13 Usual Occupation: Retired Guard
(Kind of work done during most of working life)

14 Industry or Business: Revere Sugar Refinery

15 Social Security No. 022 - 03 - 0547A

16 BIRTHPLACE (City) Chelsea
(State or country) Massachusetts

PARENTS

17 NAME OF FATHER Charles H. Epps

18 BIRTHPLACE OF FATHER (City) Kent
(State or country) England

19 MAIDEN NAME OF MOTHER Maria McGuinness

20 BIRTHPLACE OF MOTHER (City)
(State or country) Ireland

21 Informant Emily Epps
(Address) 63 Crest Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Lessard
(Signature of Agent of Board of Health or other)
Health Officer (Official Designation) 11/14/62 (Date of Issue of Permit)

VBV

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-302

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON. — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Cambridge
(City or Town making this return)

Registered No. 160805

1 PLACE OF DEATH: Middlesex (County); Cambridge (City or Town); No. Cambridge City Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: Etta C. Patchell (Shea)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR,) no

(a) Residence. No. 79 Highland Ave. St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 1 years 9 months days. In place of residence 20 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: Nov. 12, 1962 (Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from Oct. 3, 1962 to Nov. 12, 1962, or I last saw him alive on Nov. 12, 1962, death is said to have occurred on the date stated above, at 7:20a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Carcinoma Right Breast ~~with Metastases to Lungs~~
Due To
(b)
Due To
(c)

INTERVAL BETWEEN ONSET AND DEATH: 3yrs.

OTHER SIGNIFICANT CONDITIONS: General Arteriosclerosis 10-15yrs.

Was autopsy performed? no
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) Edward T. Downey, M. D.
" " "

(Address) 475 Comm. Ave. Boston Date 11-12 1962

6 Place of Burial or Cremation: Winthrop Cem. Winthrop, Mass. (City or Town)
DATE OF BURIAL: Nov. 15th 1962

7 NAME OF FUNERAL DIRECTOR: Arthur J. O'Maley
ADDRESS: Winthrop, Mass.

Received and filed DEC 6 - 1962 19
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Robert Patchell (Husband's name in full)

12 AGE 85 Years Months Days. If under 24 hours Hours. Minutes

13 Usual Occupation: Housewife (Kind of work done during most working life)

14 Industry or Business: Own Home

15 Social Security No. none

16 BIRTHPLACE (City) (State or country) Tardiff, So. Wales England

PARENTS

17 NAME OF FATHER: Patrick O'Shea

18 BIRTHPLACE OF FATHER (City) (State or country): England

19 MAIDEN NAME OF MOTHER: Margaret Dacey

20 BIRTHPLACE OF MOTHER (City) (State or country): England

21 Informant (Address): Marie L. Coulter, 79 Highland Ave. Winthrop

A TRUE COPY
ATTEST:
(Registrar of City or Town where death occurred)

DATE FILED Nov. 14, 1962

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

R-301A

STRUCTIONS OR CERTIFICATE

giving OF DEATH

not enter than one for each b) and (c)

es not mean of dying, heart failure, etc. It means or compli- which caused

ns, if any, have rise to cause (a), the under- cause last.

tions contrib- death but not the terminal ndition given

- Chapter 137, 1954, requires ans to print or he cause or of death on certificates, and r 48, Acts of equires Physi- o print or type nder signature.

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 808

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. 57 Ocean View St. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

2 FULL NAME Mary Elizabeth Foy
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 57 Ocean View Street St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months....days. In place of residence 30 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 14, 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from ——, 19—, to ——, 19—

I last saw h— alive on ——, 19—, death is said to have occurred on the date stated above, at 9:30 A.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Natural Causes

Due To (b) Presumably Coronary Occlusion

Due To (c) Hypertensive Heart Disease

OTHER SIGNIFICANT CONDITIONS Cirrhosis of Liver

INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

Was autopsy performed? no
What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) Arthur C. Murray, M. D.
Arthur C. Murray
(PRINT OR TYPE SIGNATURE)
(Address) Winthrop Board of Health Date 15 Nov 1962

6 Winthrop Cemetery Winthrop
Place of Burial or Cremation (City or Town)
DATE OF BURIAL November 17 1962

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Haley
ADDRESS Winthrop Mass.

Received and filed NOV 6 1962 19
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female
9 COLOR White
10 SINGLE, MARRIED, WIDOWED, or DIVORCED (write the word) Married

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Robert W. Foy
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 51 Years....Months....Days
If under 24 hours ....Hours....Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No.

16 BIRTHPLACE (City) Charlestown
(State or country) Mass

PARENTS

17 NAME OF FATHER ---------- Roberts

18 BIRTHPLACE OF FATHER (City) Cannot be learned
(State or country)

19 MAIDEN NAME OF MOTHER Cannot be learned

20 BIRTHPLACE OF MOTHER (City) Cannot be learned
(State or country)

21 Informant Robert W. Foy
(Address) 57 Ocean View St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sirearuzzi
(Signature of Agent of Board of Health or other)

Health Officer 11/16/62
(Official Designation) (Date of Issue of Permit)

0-928145

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R R-301

STRUCTIONS OR CERTIFICATE

Irgiving E OF DEATH

t enter rhan one for each b) and (c)

es not mean of dying, heart failure, etc. It means , or compli- which caused

ns, if any, have rise to cause (a), the under- cause last.

ntions contrib- death but not the terminal ndition given

- Chapter 137, 1954 requires ians to print or the cause or e of death on certificates, and r 48, Acts of requires Physi- o print or type nder signature.

51-930213

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 202

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. 27 Marshall Street St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Annie J. Barry (Murphy)
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 27 Marshall Street, Winthrop St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 20 years ..... months ..... days. In place of residence 20 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 15 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from — 1955, to 15 Nov 1962

I last saw her alive on 14 Nov 1962, death is said to have occurred on the date stated above, at 1 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Cerebral Hemorrhage

Due To (b) Cerebral Arteriosclerosis 10 yrs

Due To (c) Generalized Arteriosclerosis 15 yrs

OTHER SIGNIFICANT CONDITIONS none

Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Arthur C. Murray M. D.

Arthur C. Murray
(Print or Type Name)

(Address) Winthrop Mass Date 16 Nov 1962

6 Holy Cross Cemetery, Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL November 17th 1962

7 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.

ADDRESS 917 Bennington St., E. Boston

Received and filed NOV 16 1962 19..... (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 CITIZEN OF U.S.: YES ☒ NO ☐

11 SINGLE ☐ MARRIED ☒ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐

11a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Joseph H. Barry
(Husband's name in full)

12 DATE OF BIRTH Aug. 16, 1884

13 AGE 78 Years 2 Months 29 Days — If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Housewife
(Kind of work done during most of working life)

15 Industry or Business: At home

16 Social Security No. None

17 BIRTHPLACE (City) East Boston
(State or country) Mass.

PARENTS

18 NAME OF FATHER Patrick Murphy

19 BIRTHPLACE OF FATHER (City) St. Johns
(State or country) New Brunswick

20 MAIDEN NAME OF MOTHER Julia Desmond

21 BIRTHPLACE OF MOTHER (City) Quincy
(State or country) Mass.

22 Informant Joseph H. Barry-hus.
(Address) 27 Marshall St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph C. Sirianni
(Signature of Agent of Board of Health or other)

Health Officer 11/16/62
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

DRM R-302

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — MARGIN RESERVED FOR BINDING

THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

RUTLAND
(City or Town making this return)

Registered No. 208

1 PLACE OF DEATH
Worcester (County)
RUTLAND (City or Town)
Veterans Administration Hospital No. ..... St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME John Stewart Ryan
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR, WW 1

(a) Residence. No. 23 Belcher St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 5 years 30 months ..... days. In place of residence 31 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 15, 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from May 18 19 62, to November 15 19 62

Last saw alive on xxxxxxxxxx 19 xxx, 10:20 a.m. death is said to have occurred on the date stated above, at VA

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Due to Carcinomatosis - to the pelvic skin vertebrae, scapula, liver peritoneal tissues, diaphragm xxx and mediastinum. — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

(b) Due To Post operative — Days

(c) Due To Carcinoma of the bladder — 1 yr

Terminal Bronchial Pneumonia

OTHER SIGNIFICANT CONDITIONS Tuberculosis, inactive — yrs.

Was autopsy performed? Yes
What test confirmed diagnosis? Physical, x-ray & lab

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) R.Z.Schulz, Pathologist, M. D.

(Address) VAH Rutland Hts., Mass. Date Nov.15 19 62

6 Place of Burial or Cremation Winthrop Cemetery, Winthrop, Mass. (City or Town)
DATE OF BURIAL November 17, 19 62

7 NAME OF FUNERAL DIRECTOR Richard C.Kirby Inc
ADDRESS 917 Bennington St., E.Boston, Mass.

Received and filed DEC - 1962 19.....
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male

9 COLOR White

10 SINGLE (write the word) MARRIED Married WIDOWED DIVORCED UNKNOWN

11 If married, widowed, or divorced HUSBAND of Mary Jane Gagnon
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 AGE 69 Years 10 Months 21 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Air Line Purchaser
(Kind of work done during most working life)

14 Industry or Business: Northeast Air Lines

15 Social Security No. 022-05-3913

16 BIRTHPLACE (City or Town) Orient
(State or country) Long Island, N.Y.

PARENTS

17 NAME OF FATHER Maurice John Ryan

18 BIRTHPLACE OF FATHER (City) County Cork
(State or country) Ireland

19 MAIDEN NAME OF MOTHER Mary Ellen Gibbs

20 BIRTHPLACE OF MOTHER (City) Tipperay,
(State or country) Ireland

21 Informant VA Hospital Records
(Address) Rutland Heights, Mass.

A TRUE COPY
ATTEST: Linda A. Hanff
(Registrar of City or Town where death occurred)

DATE FILED Nov.15, 1962 19.....

T.V.B.V

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE 7/26/17

DATE OF DISCHARGE 8/16/19

RANK, RATING ..... Chief Yeoman 3/c

ORGANIZATION AND OUTFIT ..... Navy

SERVICE NUMBER 1747590

.....

DBI R-301A

IN RUCTIONS FOR IC. CERTIFICATE

giving S OF DEATH

d not enter me than one a e for each (b) and (c)

does not mean de of dying, heart failure, etc. It means dise, or compli- n. which caused

ntions, if any, gave rise to cause (a), ng the under- cause last.

Conditions contrib- p death but not to the terminal condition given

t - Chapter 137, 1954, requires ans to print or he cause or e of death on certificates, and r 48, Acts of equires Physi- o print or type nder signature.

c.

4-11-59-926662

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 209

X

PLACE OF DEATH

1 SUFFOLK (County)

WINTHROP (City or Town)

No. 97 LOWELL RD. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME DANIAL E FOLEY
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Residence. No. 97 LOWELL RD. St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 50 years ..... months ..... days. In place of residence 50 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 17 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 25 Oct, 1962, to 17 Nov, 1962. I last saw him alive on 13 Nov, 1962, death is said to have occurred on the date stated above, at 1:00 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma of Prostate — INTERVAL BETWEEN ONSET AND DEATH 2 yrs

Due To (b) ——

Due To (c) ——

OTHER SIGNIFICANT CONDITIONS Generalized Arteriosclerosis — yrs

Was autopsy performed? no

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? no
If so, specif

(Signed) Arthur C. Murray, M. D.
Arthur C. Murray, M.D.
(PRINT OR TYPE SIGNATURE)
(Address) Winthrop Mass Date 19 Nov 1962

6 HOLY CROSS MALDEN
Place of Burial or Cremation (City or Town)
DATE OF BURIAL NOV 20 1962

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY
ADDRESS WINTHROP

Received and filed NOV 19 1962 19.....
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE

9 COLOR WHITE

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) MARRIED

10a If married, widowed, or divorced HUSBAND of ELIZABETH VERKAMPEN
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 84 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: SCHOOL TEACHER (Retired)
(Kind of work done during most of working life)

14 Industry or Business: BOSTON PUBLIC SCHOOLS

15 Social Security No. 025-26-0452

16 BIRTHPLACE (City) BOSTON
(State or country) MASS

PARENTS

17 NAME OF FATHER PATRICK FOLEY

18 BIRTHPLACE OF FATHER (City) IRELAND
(State or country)

19 MAIDEN NAME OF MOTHER BRIDGET O'CONNOR

20 BIRTHPLACE OF MOTHER (City) BOSTON
(State or country) MASS

21 Informant ELIZABETH FOLEY
(Address) 97 LOWELL RD WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sevaoian
(Signature of Agent of Board of Health or other)

Health Officer 11/19/62
(Official Designation) (Date of Issue of Permit)

V.B.V

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

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Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

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R-301A

STRUCTIONS OR AL CERTIFICATE

Ingiving E OF DEATH

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ns, if any, have rise to e cause (a), the under- cause last.

itions contrib- death but not the terminal ndition given

Chapter 137, 954, requires ns to print or e cause or of death on rtificates, and 48, Acts of quires Physi- print or type der signature.

-6-59-925686

The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 210

PLACE OF DEATH

1 Suffolk (County) — Boston 12-6-62

Winthrop. (City or Town)

No. 39 Grovers Ave. St. (If death occurred in a hospital or institution, give its NAME instead of street and number) (Mayflower Nursing Home.

2 FULL NAME Blanche Barnes. (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. (~~39 GROVERS Ave.~~) ~~Winthrop~~ St. East Boston, Mass.
(Usual place of abode) 42 Lexington St. East Boston, Mass. (If nonresident, give city or town and State)

Length of stay: In place of death 2 years 1 months days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 22. 1962 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 1954, to Nov. 22 1962

I last saw he alive on Nov. 21 1962, death is said to have occurred on the date stated above, at 2:00 A. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pneumonia, bronchial.

INTERVAL BETWEEN ONSET AND DEATH 3days.

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS None.

Was autopsy performed? No

What test confirmed diagnosis? Clinical.

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Charles Liberman, M. D.

CHARLES LIBERMAN (PRINT OR TYPE SIGNATURE)

(Address) WINTHROP, MASS. Date Nov. 22 1962

6 WOODLAWN EVERETT, MASS
Place of Burial or Cremation (City or Town)

DATE OF BURIAL NOV. 28, 1962

7 NAME OF FUNERAL DIRECTOR ALFRED D. THOMAS

ADDRESS 4 FREMONT ST., MATTAPAN, MASS

Received and filed NOV 27 1962 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX F

9 COLOR WHITE

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) WIDOWED

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of GEORGE BARNES.
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 91 Years Months Days — If under 24 hours Hours Minutes

13 Usual Occupation: UNKNOWN
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) (State or country) WAKEFIELD, MASS

PARENTS

17 NAME OF FATHER HENRY JOHNSON

18 BIRTHPLACE OF FATHER (City) (State or country) NEWBURYPORT, MASS

19 MAIDEN NAME OF MOTHER LUCY M. NEWMAN

20 BIRTHPLACE OF MOTHER (City) (State or country) IPSWICH, MASS

21 Informant WELFARE DEPARTMENT
(Address) 43 HAWKINS ST., BOSTON, MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sullivan
(Signature of Agent of Board of Health or other)

Health Officer (Official Designation) 11/27/62 (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-302

— MARGIN RESERVED FOR BINDING — WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Cambridge
(City or Town making this return)

Registered No. 1669

1 PLACE OF DEATH
Middlesex (County)
Cambridge (City or Town)
No. Mount Auburn Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mabelle Alice Reinhard
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR, no

(a) Residence. No. 191 Somerset Avenue St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months 2 days. In place of residence 75 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 25, 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 23, 1962 to Nov. 25, 1962
I last saw him alive on Nov. 25, 1962, death is said to have occurred on the date stated above, at 5:15 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

	INTERVAL BETWEEN ONSET AND DEATH
(a) Respiratory Deficiency	3½hrs.
Due To (b) Peritonitis	3½hrs.
Due To (c) Perforated Peptic Ulcer	6hrs.
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? yes
What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) Eugene Guralnick, M. D.

(Address) 5 Bay State Rd. Boston Date 11-26 1962

6 Woodlawn Crematory Everett, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL November 28, 1962

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh
ADDRESS 174 Winthrop St. Winthrop

Received and filed DEC 6 - 1962 19.....
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Married

11 If married, widowed, or divorced
HUSBAND of .....
(or) WIFE of Herbert F. Reinhard
(Give maiden name of wife in full)
(Husband's name in full)

12 AGE 82 Years 1 Months 20 Days
If under 24 hours ....Hours....Minutes

13 Usual Occupation: Housewife
(Kind of work done during most working life)

14 Industry or Business: Own Home

15 Social Security No. 011-05-7483

16 BIRTHPLACE (City) Boston
(State or country) Massachusetts

PARENTS

17 NAME OF FATHER James Dyce

18 BIRTHPLACE OF FATHER (City) .....
(State or country) Scotland

19 MAIDEN NAME OF MOTHER Jennie Anderson

20 BIRTHPLACE OF MOTHER (City) .....
(State or country) Scotland

21 Informant Herbert F. Reinhard
(Address) 191 Somerset Ave. Winthrop

A TRUE COPY Thomas [illegible]
ATTEST: .....
(Registrar of City or Town where death occurred)

DATE FILED Nov. 27, 1962

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

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R[R-301

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OR
ACCERTIFICATE

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1-930213

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 212

PLACE OF DEATH

1 (County) SUFFOLK
(City or Town) Winthrop
No. 73 Ingleside Ave St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Annie E. Shea
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 144 Loring Rd. St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. 28, 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from October 31, 1962, to November 28, 1962, 19..... I last saw her alive on November 27, 1962, death is said to have occurred on the date stated above, at 12:45 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Metastatic carcinoma of Brain	6 weeks
Due To (b) Primary lesion in left lung	1 year
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Pathological fracture left humerus	August 1962

Was autopsy performed? no
What test confirmed diagnosis? x-ray

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify no

(Signed) John F. Collins M.D.
JOHN F. COLLINS
(Print or Type Name)
(Address) 27 Bennington St. Beachmont Date 11-29 1962

6 Place of Burial or Cremation OAK GROVE (City or Town) Medford
DATE OF BURIAL Dec 1 1962

7 NAME OF FUNERAL DIRECTOR Frederick J. MAGRATH
ADDRESS EAST BOSTON

Received and filed NOV 30 1962 19.....
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 CITIZEN OF U.S.	11 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN
Female	White	YES ☑ NO ☐	WIDOWED ☑

11a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Charles E. Shea
(Husband's name in full)

12 DATE OF BIRTH

13 AGE 74 Years.....Months.....Days. If under 24 hours .....Hours.....Minutes

14 Usual Occupation: House wife
(Kind of work done during most of working life)

15 Industry or Business: Own Home

16 Social Security No. CNDI

17 BIRTHPLACE (City) EAST BOSTON
(State or country) MASS

PARENTS

18 NAME OF FATHER Patrick Mullen

19 BIRTHPLACE OF FATHER (City) South Boston
(State or country) MASS

20 MAIDEN NAME OF MOTHER MARY E. Leahy

21 BIRTHPLACE OF MOTHER (City) .....
(State or country) Ireland

22 Informant MARGARET McCARTHY
(Address) 144 Loring Rd. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Lindquist
(Signature of Agent of Board of Health or other)

Health Officer 11/30/62
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

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R-301A

STRUCTIONS
OR
CERTIFICATE

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Chapter 137,
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of death on
rtificates, and
48, Acts of
quires Physi-
print or type
der signature.

6-59-925686

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 213

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

2 FULL NAME Carrie E (Tewksbury) Duncan
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 195 Main Street St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..years.. months 1 days. In place of residence 87 years 4 months 27 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. (Month) 29 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov., 1955, to Nov 29, 1962, I last saw her alive on Nov 29, 1962, death is said to have occurred on the date stated above, at 1:15 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Myocardial Heart Disease	yrs
Due To (b) Arteriosclerosis generalized	yrs
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Senility	

Was autopsy performed?
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Joseph Gregorie M. D.
JOSEPH GREGORIE M.D.
(PRINT OR TYPE SIGNATURE)
(Address) 194 Washington Ave Date 11/29/62

6 Winthrop Place of Burial or Cremation (City or Town) Winthrop
DATE OF BURIAL Dec. 2 1962

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds
ADDRESS Winthrop, Mass

Received and filed DEC 3 - 1962 19..
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female
9 COLOR White
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Married

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of George Duncan
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 87 Years 4 Months 27 Days | If under 24 hours ..Hours..Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No. 016-26-2653E

16 BIRTHPLACE (City) Winthrop
(State or country) Mass.

PARENTS

17 NAME OF FATHER John Tewksbury

18 BIRTHPLACE OF FATHER (City) Winthrop
(State or country) Mass

19 MAIDEN NAME OF MOTHER Caroline Banks

20 BIRTHPLACE OF MOTHER (City)
(State or country) Nova Scotia

21 Informant George Duncan
(Address) 195 Main Street Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Walter E. Jones
(Signature of Agent of Board of Health or other)
Health Officer 12/3/62
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

DM R-303

for burial permit
Board of Health
or's Agent.

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-9-61-931348

DEC 3 - 1962

X

1 PLACE OF DEATH: SUFFOLK (County) WINTHROP (City or Town)

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 214

No. 55 Fremont St., Winthrop St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) No

2 FULL NAME LAURA JEAN ~~VALLENCOURT~~ (Vaillancourt)
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 55 Fremont St., Winthrop St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 2 years months days. In place of residence 2 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November (Month) 30, (Day) 1962 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Smoke inhalation with carbon monoxide poisoning.

5 Accident, suicide, or homicide (specify) Accident

Date and hour of injury November 30, 19 62

IF ACCIDENTAL, was injury causally related to the death? Yes

Where did Injury occur? Winthrop, Massachusetts (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? Home (Specify type of place)

Manner of Injury Inhalation of smoke from (How did injury occur?)

Nature of Injury accidental conflagration.

While at work? Was autopsy performed? Yes

6 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Michael A. Luongo, M. D.
Michael A. Luongo, M.D.
(Print or Type Name)

(Address) Boston Date 12/1 19 62

7 Place of Burial, or Cremation. Winthrop (City or Town) Winthrop Mass

DATE OF BURIAL Dec. 3 19 62

8 NAME OF FUNERAL DIRECTOR Ernest P Caggiano
ADDRESS 147 Winthrop St, Winthrop

Received and filed DEC 3 1962 19

A TRUE COPY ATTEST: (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Female

10 COLOR White

11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Single

12 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

13 DATE OF BIRTH June 18 1960

14 AGE 2 Years Months Days If under 24 hours Hours Minutes

15 Usual Occupation
(Kind of work done during most of working life)

16 Industry or Business

17 Social Security No.

18 BIRTHPLACE (City) Boston (State or country) Mass

PARENTS

19 NAME OF FATHER Wilfred Vaillancourt

20 BIRTHPLACE OF FATHER (City) Old Town (State or country) Maine

21 MAIDEN NAME OF MOTHER Edna Turner

22 BIRTHPLACE OF MOTHER (City) Saugus (State or country) Mass

23 Informant Thomas Turner
(Address) 54 Buchanan St, Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Simmons
(Signature of Agent of Board of Health or other)

Health Officer 12/3/62
(Official Designation) (Date of Issue of Permit)

X

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

215

SEP 7 1962

NORTH CAROLINA STATE BOARD OF HEALTH
OFFICE OF VITAL STATISTICS

CERTIFICATE OF DEATH

25057

REGISTRATION DISTRICT NO. 77-00 REGISTRAR'S CERTIFICATE NO.

1. PLACE OF DEATH
a. COUNTY: Richmond
b. TOWNSHIP: Marks Creek
c. LENGTH OF STAY (in 1a):
d. CITY OR TOWN: Hamlet
Is Place of Death Within City Limits? YES ☐ NO ☒
e. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Highway 381, 2Mi. E-of Hamlet

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Mass.
b. COUNTY: Suffolk
c. CITY OR TOWN: Winthrop
Is Place of Residence: In City Limits? YES ☐ NO ☐ On a Farm? YES ☐ NO ☐
d. STREET ADDRESS or R. F. D. NO.: 398 Shirley St.

3. NAME OF DECEASED (Type or Print): First: James Middle: Peter Last: Brannan
4. DATE OF DEATH: Month Day Year: Aug. 15, 1962
5. SEX: Male
6. COLOR OR RACE: Cau
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11 Apr. 1939
9. AGE (In years last birthday): 23 IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Officer
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Army
11. BIRTHPLACE (State or foreign country): Winthrop, Mass.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: James Norman Brannan
14. MOTHER'S MAIDEN NAME: Unknown
NAME OF HUSBAND OR WIFE:
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes, 1 Nov. 61 to present
16. SOCIAL SECURITY NO.: 01-030-9307
17. INFORMANT'S NAME AND ADDRESS: Army Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH—ENTER ONLY ONE CAUSE PER LINE FOR (a), (b) and (c). INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Massive 3rd degree Burns.

ANTECEDENT CAUSES—Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Helicopter accident

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

860X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☒ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: MONTH, DAY, YEAR 8-15-62 HOUR 1 M.
20d. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Hwy.
20f. CITY OR TOWNSHIP: Hamlet COUNTY: Richmond STATE: NC

21. I attended the deceased from 8-15-62, 19..., to ..., 19..., and last saw her/him alive on ..., 19...
Death occurred at 1:50 p.m. on the date stated above; and to the best of my knowledge from the causes stated.

22a. SIGNATURE: [illegible] (Degree or title): Coroner
22b. ADDRESS: Rockingham NC.
22c. DATE SIGNED: 8-16-62

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 8-16-62
23c. NAME OF CEMETERY OR CREMATORY: Removed to Ft. Bragg, N.C.
23d. LOCATION (City, town, or county) (State): Fayetteville, N.C.

24. DATE REC'D BY LOCAL REG.: 8-16-62
25. REGISTRAR'S SIGNATURE: [illegible]
26. FUNERAL DIRECTOR: Wilson & Harrington ADDRESS: Hamlet, N.C.

This is a legal record and will be permanently filed.

Type or write legibly. Use black ink.

All items must be complete and accurate.

The undertaker, or person acting as such, is responsible for filing the completed certificate with registrar of the district where death occurred.

The physician last in attendance is required to state the cause of death and sign the medical certification.

If there was no doctor in attendance, medical certification to be completed by local Health Officer, (or Coroner, if inquest was held).

FORM 8 Rev. 1-56

17 1962

ORM R-301

for burial permit
board of Health
its Agent.

INSTRUCTIONS FOR DEATH CERTIFICATE

PRINT OR TYPE
OR CAUSES
DEATH

not enter
than one
for each
(b) and (c)

does not mean
of dying,
heart failure,
etc. It means
ase, or compli-
which caused

tions, if any,
gave rise to
cause (a),
the under-
cause last.

Conditions contrib-
death but not
to the terminal
condition given

Director
use only
ACK Ink.
28 1962
-62-932382

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT-OF-TOWN 216

Registered No. 10188

PLACE OF DEATH
1 SUFFOLK (County)
BOSTON (City or Town)
No. MASSACHUSETTS GENERAL HOSPITAL

(If death occurred in hospital or institution, state name instead of street and number)

PHYSICIAN — IMPORTANT
Was deceased a U.S. War Veteran? No

2 FULL NAME Mark M. Goldoff
(If deceased is a married, widowed or divorced woman, give also maiden name)

(a) Residence, No. 21 Sturgis Street Winthrop, Massachusetts
(Usual place of abode) (City or Town and State)

Length of stay: In place of death years months 1 days In place of residence 19 years months days

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October (Month) 18 (Day) 1962 (Year)

I HEREBY CERTIFY that I attended deceased from Oct. 18 62 to October 18 1962 and last saw him alive on October 18 1962 and death is said to have occurred on the date stated above, at 4:00p m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Pulmonary edema	Unk Min
Due To (b) Myocardial infarct	1 Wk
Due To (c) Coronary heart disease	Unk Yrs
OTHER SIGNIFICANT CONDITIONS Diabetes Mellitus	Unk Yrs

Was autopsy performed? yes
What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signature) Ch. Clay, M. D.
Charles L. Clay, M.D.
(Print or Type Name)
(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date Oct. 18 62

6 Meretzer Woburn
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct 21, 1962

7 NAME OF FUNERAL DIRECTOR Arnold Golov

ADDRESS 1668 Beacon St Brookline

Received and filed OCT 23 1962
Charles H. Mackie
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Male
9 COLOR White
10 CIVIL STATUS Married
11 If married, widowed or divorced: HUSBAND of Selma Baker (Give maiden name in full)
(or) WIFE of (Husband's name in full)
12 AGE 62 Years Months Days If under 24 hours: Hours Minutes
13 Usual Occupation Mfg. Ladies Dress
14 Industry or Business Retired
15 Social Security No. 013-05-8728
16 BIRTHPLACE (City) (State or country) Boston Mass.

PARENTS
17 NAME OF FATHER Benjamin Goldoff
18 BIRTHPLACE OF FATHER (City) (State or country) Russia
19 MAIDEN NAME OF MOTHER Julia C B L
20 BIRTHPLACE OF MOTHER (City) (State or country) Russia

21 Informant Selma Goldoff
(Address) 21 Sturgis St Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
(Signature of Agent of Board of Health or other)
(Official Designation) (Date of Issue of Permit) Oct 21 1962

A TRUE COPY ATTEST:

DRM R-301

...et or burial permit
...Bird of Health
...s Agent.

INSTRUCTIONS FOR ...A CERTIFICATE

...N OR TYPE
...ER CAUSES
...DEATH

...o not enter
...or than one
...u for each
...a (b) and (e)

...s oes not mean
...me of dying,
...a heart failure,
...ic etc. It means
...ise, or compli-
...s which caused

...ons, if any,
...gave rise to
...cause (a),
...the under-
...g cause last.

...ditions contrib-
...death but not
...o the terminal
...ondition given

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...28 1962

...62-932382

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT OF TOWN 217
(City or Town making this return)

Registered No. 10236

1 PLACE OF DEATH
Suffolk (County)
Boston (City or Town)
No. 29 Breed (If death occurred in a hospital or institution, St. give its NAME instead of street and number)

2 FULL NAME Maria Ferrara (Velardo)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence, No. 147 Winthrop St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 19, 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1962 to October 19, 1962
I last saw ER alive on October 18, 1962, death is said to have occurred on the date stated above, at 8 30 A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 days
Due To (b) Coronary Heart Disease — 7 yrs
Due To (c) —
OTHER SIGNIFICANT CONDITIONS: CA - Left Breast Metastasis to Spine. — 6 yrs, 2 yrs.

Was autopsy performed? No
What test confirmed diagnosis? E.K.G.

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) D. Thomas Shaffier M. D.
D. THOMAS SHAFFIER MD
(Print or Type Name)
(Address) 21 BACE ST EB Date Oct. 20 1962

6 Place of Burial or Cremation: Winthrop Cemetery, Winthrop (City or Town)
DATE OF BURIAL October 22, 1962

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano
ADDRESS 147 Winthrop St., Winthrop

Received and filed OCT 23 1962
Charles H. Mackie (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female
9 COLOR: white
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): widowed

11 If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of Frank Ferrara (Husband's name in full)

12 AGE 70 Years ..... Months ..... Days. If under 24 hours: Hours ..... Minutes

13 Usual Occupation: Housewife (Kind of work done during most working life)

14 Industry or Business: at home

15 Social Security No.

16 BIRTHPLACE (City) Messina (State or country) Italy

PARENTS
17 NAME OF FATHER: Joseph Velardo
18 BIRTHPLACE OF FATHER (City) Messina (State or country) Italy
19 MAIDEN NAME OF MOTHER: ?
20 BIRTHPLACE OF MOTHER (City) Messina (State or country) Italy

21 Informant (Address): Rita Donahue, 29 Breed St., E. Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Jacqueline Vinciate
(Signature of Agent of Board of Health or other)
13425 (Official Designation) 10-22-62 (Date of Issue of Permit)

A TRUE COPY ATTEST:

FORM R-301

...d for burial permit
...board of Health
...its Agent.

...STRUCTIONS
FOR
...OMIL CERTIFICATE

...RIT OR TYPE
...L OR CAUSES
...F DEATH

... not enter
...re than one
...se for each
...), (b) and (c)

...h does not mean
...ode of dying,
...h's heart failure,
...ea, etc. It means
...ease, or compli-
...on which caused
...

...ditions, if any,
...hich gave rise to
...e cause (a),
...ing the under-
...ying cause last.

...nditions contrib-
...uto death but not
...to the terminal
...e condition given
...

...risdiction
...declined by
...edical
...xaminer

...C 28 1962

...12-62-932382

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT - OF - T 218

(City or Town making this return)

Registered No. 10382

1 PLACE OF DEATH: Suffolk (County); Boston (City or Town); No. Veterans Administration Hospital (If death occurred in a hospital or institution, St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT: (Was deceased a U. S. War Veteran, if so specify WAR) WWI

2 FULL NAME: Edward J. CAHILL (If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence, No. 78 Atlantic St. Winthrop, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ... years ... months -1 days. In place of residence 35 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: October (Month) 25 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from October 25, 1962, to October 25, 1962, death is said to have occurred on the date stated above, at 5:30 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Congestive heart failure secondary to arteriosclerotic heart disease.

Due To (b) ...

Due To (c) ...

OTHER SIGNIFICANT CONDITIONS ...

INTERVAL BETWEEN ONSET AND DEATH: Unk.

Was autopsy performed? No

What test confirmed diagnosis? Clinical findings

5 Was disease or injury in any way related to occupation of deceased? ... If so, specify ...

(Signature) Arthur Lee, M. D.
(Print or Type Name)

(Address) VAH, Boston, Mass. Date 10-25-1962

6 Place of Burial or Cremation: ~~Holy Cross~~ Winthrop ~~Malden, Mass.~~ (City or Town)

DATE OF BURIAL October 29, 1962

7 NAME OF FUNERAL DIRECTOR: Arthur J. O'Maley

ADDRESS: 79 Atlantic St. Winthrop, Mass.

Received and filed OCT 29 1962, 19...

Charles F. Mackie (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Married

11 If married, widowed or divorced, HUSBAND of Elizabeth Dearie (Give maiden name of wife in full)

(or) WIFE of ... (Husband's name in full)

12 AGE 67 Years ... Months ... Days. If under 24 hours: Hours ... Minutes

13 Usual Occupation: Ret. Rigger (Kind of work done during most working life)

14 Industry or Business: U.S. Naval Shipyard

15 Social Security No. 018 12 3792

16 BIRTHPLACE (City) (State or country): St. Johns Newfoundland

PARENTS

17 NAME OF FATHER: James Cahill

18 BIRTHPLACE OF FATHER (City) (State or country): Newfoundland

19 MAIDEN NAME OF MOTHER: Mary Squires

20 BIRTHPLACE OF MOTHER (City) (State or country): England

21 Informant (Address): VA Hospital Records, 150 S. Huntington Ave., Boston 30 Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit) Oct. 28 1962

A TRUE COPY ATTEST:

M R-301

NSTRUCTIONS FOR L CERTIFICATE

n giving E OF DEATH

not enter e than one ase for each , (b) and (c)

dors not mean ode of dying, heart failure, , etc. It means ease, or compli- which caused

ntions, if any, gave rise to cause (a), g the under- cause last.

Conditions contrib- death but not to the terminal condition given

te:- Chapter 137, of 1954 requires sicians to print or the cause or es of death on h certificates, and pter 48, Acts of , requires Physi- s to print or type e under signature. M.C.

C 28 1962

3-61-930213

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

219

To be filed for burial permit with Board of Health or its Agent

Registered No. 10416

PLACE OF DEATH

1 Suffolk (County)
Jamaica Plain (City or Town)
Lemuel Shattuck Hospital
180 Morton St
(If death occurred in a hospital or institution, St. give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Gilbert (GILLIS) LEWIS
(First Name) (Middle Name) (Last Name)

(Was deceased a U. S. War Veteran, if so specify WAR) NO

21 (If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence No. 235 Pleasant Park Rd (Usual place of abode) Winthrop
(If nonresident, give city or town and State)

Length of stay In place of death years months 35 days In place of residence 48 years months days

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October (Month) 25 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 9/20, 1962, to 10/25, 1962

I last saw h. alive on 10/25/62, 1962, death is said to have occurred on the date stated above, at 2:55 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) BLEEDING ESOPHAGEAL VARICES

Due To (b) LAENNEC'S CIRRHOSIS

Due To (c)

OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH 13 YRS

Was autopsy performed? YES

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? If so, specify NO

(Signed) Robert J. Cinseman, M. D.
ROBERT J. CINSEMAN
(Print or Type Name)
(Address) SHATTUCK HOSP. Date 10/25 1962

6 WINTHROP Place of Burial or Cremation WINTHROP (City or Town)

DATE OF BURIAL OCT 27 1962

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY

ADDRESS WINTHROP

Received and filed OCT 29 1962 19

Charles H. Mackie (Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE 9 COLOR WHITE 10 CITIZEN OF U.S. YES X NO 11 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN

12a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of EVERETT LEWIS (Husband's name in full)

12 DATE OF BIRTH Nov 26 1914

13 AGE 48 Years Months Days If under 24 hours Hours Minutes

14 Usual Occupation: CLERK (Kind of work done during most of working life)

15 Industry or Business: HOTEL

16 Social Security No. NOT KNOWN

17 BIRTHPLACE (City) WINTHROP (State or country) MASS

PARENTS

18 NAME OF FATHER FREDERICK A GILLIS

19 BIRTHPLACE OF FATHER (City) EAST BOSTON (State or country) MASS

20 MAIDEN NAME OF MOTHER MARY E MCCARTHY

21 BIRTHPLACE OF MOTHER (City) EAST BOSTON (State or country) MASS

22 Informant WALTER LEWIS
(Address) 182 HERMON ST WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

R. J. Kogelman
(Signature of Agent of Board of Health or other)

-4B13562 (Official Designation) 11/6/62 (Date of Issue of Permit)

COPY ATTEST:
Charles H. Mackie
City Registrar

FORM R-302

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON. — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

M.C.

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Registered No. 220

Everett (City or Town making this return)

1 PLACE OF DEATH: Middlesex (County); Everett (City or Town); No. Whidden Memorial Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: Joseph H. De Foe (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR, WW I)

(a) Residence. No. 56 Court Rd., St. Winthrop, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months 28 days. In place of residence 17 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: November (Month) 2, (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Oct. 5, 1962, to Nov. 2, 1962. I last saw him alive on November 2, 1962, death is said to have occurred on the date stated above, at 3:30 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Acute Pulmonary Edema	10-5-62
Due To (b)	Chronic Myocarditis	1961
Due To (c)	Acute Dilatation Heart	11-2-62
OTHER SIGNIFICANT CONDITIONS		

Was autopsy performed? No
What test confirmed diagnosis? Clinical Findings

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) John F. Williams, M. D.
(Address) 596 Broadway, Everett, Mass. Date 11-2-62 19

6 Place of Burial or Cremation: Holy Cross Cemetery, Malden, Mass (City or Town)
DATE OF BURIAL November 5, 1962

7 NAME OF FUNERAL DIRECTOR: Madeline G. Casey
ADDRESS 295 Wash. Ave., Chelsea

Received and filed DEC 12 1962 19 62

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Married

11 If married, widowed, or divorced HUSBAND of Mary B. (Casey) DeFoe (Give maiden name of wife in full)
(or) WIFE of ....(Husband's name in full)

12 AGE 69 Years — Months — Days. If under 24 hours ....Hours....Minutes

13 Usual Occupation: Engineer (Kind of work done during most working life)

14 Industry or Business: Retired

15 Social Security No. 016-16-9251

16 BIRTHPLACE (City) Westboro (State or country) Mass.

PARENTS

17 NAME OF FATHER: George De Foe

18 BIRTHPLACE OF FATHER (City) Natick (State or country) Mass.

19 MAIDEN NAME OF MOTHER: Alice Comiskey

20 BIRTHPLACE OF MOTHER (City) Westboro (State or country) Mass.

21 Informant (Address): Mrs. Mary B. De Foe, 56 Court Rd., Winthrop, Mass.

A TRUE COPY
ATTEST: [signature] (Registrar of City or Town where death occurred)
DATE FILED November 5, 1962

SPACE FOR ADDITIONAL INFORMATION Prior Service July 18,1918-Sept.17,1918

DATE OF ENTERING MILITARY SERVICE Oct. 23, 1918 (2nd enlistment)

DATE OF DISCHARGE Dec. 10, 1918

RANK, RATING Act. Sgt.

ORGANIZATION AND OUTFIT S.A.T.C. Tufts College, Mass.

SERVICE NUMBER 593035

FORM R-302

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — MARGIN RESERVED FOR BINDING — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Registered No. 607 221

(City or Town making this return) Chelsea

1 PLACE OF DEATH: Suffolk (County); Chelsea (City or Town)

No. Chelsea Memorial Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Edward J. Sheehan (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR,) WW2

(a) Residence. No. 83 Chester Ave. St. / Winthrop, Mass. (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death - years - months 8 days. In place of residence 8 years - months - days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. 23, 1962 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 16, 1962, to Nov. 23, 1962. I last saw him alive on Nov. 23, 1962, death is said to have occurred on the date stated above, at 7:40p. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a)

Due to (b) Massive pulmonary embolus — INTERVAL BETWEEN ONSET AND DEATH: sudden

Due To (c) Post operative Nov. 16, 1962

Annular carcinoma sigmoid — ?mos.

OTHER SIGNIFICANT CONDITIONS: Complete obstruction of sigmoid — Nov. 16/62

Was autopsy performed? yes

What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) , M. D.

(Address) Charles M. Stearns Date 19

6 Place of Burial or Cremation: 116 Hawthorn St., Chelsea, Mass. (City or Town) Nov. 26 62

Holy Cross, Malden, Mass.

DATE OF BURIAL Nov. 27, 1962 19

7 NAME OF FUNERAL DIRECTOR John G. Welsh

ADDRESS 718 Broadway, Chelsea, Mass.

Received and filed DEC 14 1962 19

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Married

11 If married, widowed, or divorced HUSBAND of Margaret Carolan (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 AGE Years Months Days — If under 24 hours Hours Minutes

13 usual Occupation: - - (Kind of work done during most working life) Master Sargeant

14 Industry or Business: National Guard

15 Social Security No.

16 BIRTHPLACE (City) (State or country) Boston, Mass.

PARENTS

17 NAME OF FATHER Michael Sheehan

18 BIRTHPLACE OF FATHER (City) (State or country) Ireland

19 MAIDEN NAME OF MOTHER Julia Deasey

20 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

21 Informant (Address) Margaret Sheehan 83 Chester Ave., Winthrop, Mass.

A TRUE COPY ATTEST: Joseph A. Tyrrell (Registrar of City or Town where death occurred)

DATE FILED November 26, 1962 19

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

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MR-301A

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100M-11-55-916145

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 222

PLACE OF DEATH

1 SUFFOLK (County)

WINTHROP (City or Town)

No. 175 SHIRLEY ST St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME AIMEE E. (PUTNAM) PAYNE
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) NO.

(a) Residence. No. 175 SHIRLEY ST St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 79 years ..... months ..... days. In place of residence 79 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 3, 1962.
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from July, 1956, to December 3 1962
I last saw he alive on December 3 1962; death is said to have occurred on the date stated above, at 3:25 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Cerebral Hemorrhage	48 hrs
Due To (b)	Arterial Hypertension	12 yrs
Due To (c)		
OTHER SIGNIFICANT CONDITIONS	Pulmonary Tuberculosis	3 yrs
	Thoracoplasty, left.	2 yrs

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Charles Liberman, M. D.
(Address) WINTHROP, MASS Date 12/4/1962

6 WINTHROP Place of Burial or Cremation WINTHROP (City or Town)
DATE OF BURIAL DEC 6 1962

7 NAME OF FUNERAL DIRECTOR MAURICE W. NIRBY
ADDRESS WINTHROP.

Received and filed DEC 5 - 1962 19
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX FEMALE | 9 COLOR WHITE | 10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word) WIDOWED

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of JOHN L PAYNE
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 79 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: HOME MAKER
(Kind of work done during most of working life)

14 Industry or Business: OWN HOME

15 Social Security No. NONE

16 BIRTHPLACE (City) WINTHROP
(State or country) MASS

PARENTS

17 NAME OF FATHER JOHN R PUTNAM

18 BIRTHPLACE OF FATHER (City) WINTHROP
(State or country) MASS.

19 MAIDEN NAME OF MOTHER MARGARET TAYLOR

20 BIRTHPLACE OF MOTHER (City) YARMOUTH
(State or country) MASS.

21 Informant MRS VIRGINIA McREGUAH.
(Address) 175 SHIRLEY ST WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph C. Williams
(Signature of Agent of Board of Health or other)

Health Officer 12/5/62
(Official Designation) (Date of Issue of Permit)

EXTRACTS

FROM THE LAWS OF THE

COMMONWEALTH OF MASSACHUSETTS

GOVERNING THE

RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . .Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourte n, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. .. — General Laws, Chap. 38, Sec. 6., as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made.
. . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

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FRM R-301

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2-932382

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 223

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. Bay View Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Edith (Hamilton) Croxford (Hamilton)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 1 Washington Terrace St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 10 years ..... months ..... days. In place of residence 55 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December (Month) 6 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 1, 1960, to December 6, 1962

I last saw her alive on December 6, 1962, death is said to have occurred on the date stated above, at 4:10 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Acute Cerebral Hemorrhage	45 min
Due To (b) Hypertension	10 yrs
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Left Hemiparesis. Right Hemiparesis	1 year 8 mos.

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Dorothy Cheney Appleton, M. D.
DOROTHY CHENEY APPLETON
(Print or Type Name)

(Address) 197 Woodside Ave Winthrop, Mass Date Dec. 7 1962

Mayflower Cemetery Duxbury, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 10, 1962

7 NAME OF FUNERAL DIRECTOR Alfred B. Marsh

ADDRESS 174 Winthrop St. Winthrop,

Received and filed DEC 10 1962 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female

9 COLOR: white

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): widowed

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of John Sanborn Croxford
(Husband's name in full)

12 AGE 79 Years 4 Months 16 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: housework
(Kind of work done during most working life)

14 Industry or Business: own home

15 Social Security No. none

16 BIRTHPLACE (City) (State or country) Duxbury, Massachusetts

PARENTS

17 NAME OF FATHER John Walter Hamilton

18 BIRTHPLACE OF FATHER (City) Quincy (State or country) Massachusetts

19 MAIDEN NAME OF MOTHER Georgianna Prior

20 BIRTHPLACE OF MOTHER (City) Duxbury (State or country) Massachusetts

21 Informant Mrs. Eugene Martinez
(Address) 1 Washington Terrace

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sullivan
(Signature of Agent of Board of Health or other)

Health Officer 12/10/62
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R-301A

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6-59-925686

The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 224

PLACE OF DEATH

1 Suffolk (County)
Winthrop (City or Town)
No. 16 Woodside Park St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME James F Evans (Was deceased a U. S. War Veteran, if so specify WAR) -
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 16 Woodside Park St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 61 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 6, 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from August 12, 1962, to December 6, 1962, 19..
I last saw him alive on December 5, 1962, 19.., death is said to have occurred on the date stated above, at 7:40 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Glioblastoma of Basal Ganglion — INTERVAL BETWEEN ONSET AND DEATH: May 1962

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS none

Was autopsy performed? no
What test confirmed diagnosis? Cranial exploratory operation June 22, 1962
5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) John F. Collins M.D., M. D.
(PRINT OR TYPE SIGNATURE) John F. Collins, M.D.
(Address) 27 Bennington Street Revere, Mass. Date Dec. 7, 1962

6 Winthrop Cemetery Winthrop
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Dec. 10, 1962, 19..

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds
ADDRESS Winthrop Mass.

Received and filed DEC 11 - 1962, 19..
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Married

10a If married, widowed, or divorced, HUSBAND of Marion Cosgrove
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 61 Years 5 Months 26 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Engineer
(Kind of work done during most of working life)

14 Industry or Business: Locomotive Railroad

15 Social Security No. 025-09-7799

16 BIRTHPLACE (City) Lynn
(State or country) Mass.

PARENTS

17 NAME OF FATHER Robert Evans

18 BIRTHPLACE OF FATHER (City)
(State or country) Newfoundland

19 MAIDEN NAME OF MOTHER Isabel Stidstone

20 BIRTHPLACE OF MOTHER (City)
(State or country) Newfoundland

21 Informant Marion Evans
(Address) 16 Woodside Park, Winthrop, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Swanson
(Signature of Agent of Board of Health or other)

Health Officer 12/7/62
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

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The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 225

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Margaret (First Name) Murphy (Last Name) (Middle Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 9 Tewksbury St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months 18 days. In place of residence 20 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 6, 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from June 20, 1962 19..., to December 6, 1962, 19...
I last saw him alive on December 6, 1962, death is said to have occurred on the date stated above, at 6:55 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Metastatic carcinoma - primary in the sigmoid	May 1962
Due To (b) Hypertensive heart disease	2 yrs.
Due To (c) Hypertension	4 yrs.
OTHER SIGNIFICANT CONDITIONS	

Was autopsy performed? no
What test confirmed diagnosis? X-ray findings.

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) John F. Collins M.D., M. D.
John F. Collins, M.D.
(PRINT OR TYPE SIGNATURE)
(Address) 27 Bennington St. Date Dec. 7, 1962
Revere, Mass.

6 Place of Burial or Cremation St. James Cemetery Haverhill (City or Town)

DATE OF BURIAL December 10, 1962

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass.

Received and filed DEC 7 - 1962 19...
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female

9 COLOR White

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Single

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 75 Years....Months....Days If under 24 hours ....Hours....Minutes

13 Usual Occupation: Practical Nurse
(Kind of work done during most of working life)

14 Industry or Business: Nursing

15 Social Security No. 020-09-9438

16 BIRTHPLACE (City) (State or country) Ireland

PARENTS

17 NAME OF FATHER Michael Murphy

18 BIRTHPLACE OF FATHER (City) (State or country) Ireland

19 MAIDEN NAME OF MOTHER Mary McCarthy

20 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

21 Informant John Fitzgerald
(Address) 75 5th Ave., Haverhill

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Sprague, M.D.
(Signature of Agent of Board of Health or other)

Health Officer 12/7/62
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R-303

burial permit
d of Health
Agent.

information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-9-61-931348

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(City or Town making this return) .....

Registered No. 226

1 PLACE OF DEATH

SUFFOLK (County)

WINTHROP (City or Town)

No. 39 Banks Street, Winthrop St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME MARGARET ANN CADIGAN
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Residence, No. 39 Banks Street, Winthrop St. MASS
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 9 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 7, 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Asphyxia due to strangulation by ligature.

5 Accident, suicide, or homicide (specify) Homicide.

Date and hour of injury December 7, 19 62

IF ACCIDENTAL, was injury causally related to the death? .....

Where did Injury occur? Winthrop, Mass.
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? Home.
(Specify type of place)

Manner of Injury Strangulation by ligature
(How did injury occur?)

Nature of Injury (cotton pajama bottom).

While at work? ..... Was autopsy performed? Yes

6 Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) Michael A. Luongo, M. D.
Michael A. Luongo, M.D.
(Print or Type Name)

(Address) Boston Date 12/8 19 62

7 Place of Burial, or Cremation WINTHROP (City or Town) WINTHROP

DATE OF BURIAL DEC. 12, 19 62

8 NAME OF FUNERAL DIRECTOR DIPIETRO & VAZZA

ADDRESS 11 HENRY ST, EAST BOSTON

Received and filed DEC 13 1962 19.....

PERSONAL AND STATISTICAL PARTICULARS

9 SEX FEMALE

10 COLOR WHITE

11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN SINGLE

12 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

13 DATE OF BIRTH 4/29/45

14 AGE 17 Years.....Months.....Days If under 24 hours .....Hours.....Minutes

15 Usual Occupation STUDENT
(Kind of work done during most of working life)

16 Industry or Business HIGH SCHOOL

17 Social Security No. 017-34-5430

18 BIRTHPLACE (City) (State or country) WINTHROP, MASS.

PARENTS

19 NAME OF FATHER JOHN L. CADIGAN

20 BIRTHPLACE OF FATHER (City) BOSTON (State or country) MASS

21 MAIDEN NAME OF MOTHER HILDA M. DIPIETRO

22 BIRTHPLACE OF MOTHER (City) BOSTON (State or country) MASS

23 Informant JOHN L. CADIGAN
(Address) 39 BANKS ST, WINTHROP, MASS.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Walter C. Sullivan
(Signature of Agent of Board of Health or other)

Health Officer
(Official Designation)

12/11/62
(Date of Issue of Permit)

MEDICAL

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

FRM R-301

or burial permit
Bd of Health
Agent.

STRICTIONS
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 227

PLACE OF DEATH: Suffolk (County); Winthrop (City or Town); No. 226 Cottage Park Rd. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary Carpenter (Barden)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No. 226 Cottage Park Rd. St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years 6 months ....days. In place of residence ....years 6 months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 9, 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY That I attended deceased from Dec 3, 1962, to Dec. 9, 1962, I last saw he alive on Dec 9, 1962 death is said to have occurred on the date stated above, at 11:35 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

		INTERVAL BETWEEN ONSET AND DEATH
(a)	Myocardial Heart Disease	yrs
Due To (b)	Arteriosclerosis - generalized	yrs
Due To (c)		
OTHER SIGNIFICANT CONDITIONS	Carcinoma - abdominal wall	yrs

Was autopsy performed?
What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Joseph Gregorie, M. D.
Joseph GREGORIE
(Print or Type Name)
(Address) 194 Washington St. Date 12-11 1962

6 Place of Burial or Cremation: Fantine Kill Cemetery, Ellenville, New York (City or Town)
DATE OF BURIAL December 13, 1962

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano
ADDRESS 147 Winthrop Street, Winthrop

Received and filed DEC 1962 19....
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN
female	white	widowed

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Daniel Carpenter
(Husband's name in full)

12 AGE 86 Years 5 Months 24 Days — If under 24 hours .... Hours .... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most working life)

14 Industry or Business: at home

15 Social Security No.

16 BIRTHPLACE (City) New York
(State or country) New York

PARENTS

17 NAME OF FATHER Everett Barden

18 BIRTHPLACE OF FATHER (City)
(State or country) New York

19 MAIDEN NAME OF MOTHER Alice Holmes

20 BIRTHPLACE OF MOTHER (City)
(State or country) New York

21 Informant Mrs. Alice Cole
(Address)
226 Cottage Park Rd., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Walter E. Turnamian
(Signature of Agent of Board of Health or other)
Health Officer 12/12/62
(Official Designation) (Date of Issue of Permit)

2-932382

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R-305

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-3-61-930213

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

PALMER (City or town making return)

Registered No. 228

1 PLACE OF DEATH: Hampden (County); Palmer (City or Town)

No. Wing Memorial Hosp. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Peter Blomquist (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) --

(a) Residence. No. 19 Pleasant St. Winthrop, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death -- years -- months 1 days. In place of residence 22 years - months - days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 10, 1962. (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Fractured neck; fractured ribs - right & punctured lung: compound fracture - right ankle

5 Accident, suicide, or homicide (specify) Accident

Date and hour of injury 1:45 AM-12/10/ 19 62.

If accidental, was injury causally related to the death? Yes

Where did Injury occur? Ludlow, Mass. (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? Turnpike (Specify type of place)

Manner of Injury Car skidded & hit guard rail (How did injury occur?)

Nature of Injury Thrown out of car & killed

While at work? No Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Benjamin Schneider, M. D.

(Address) Monson, Mass. Date 12/10 19 62

7 Place of Burial or Cremation. Winthrop Cem., Winthrop, Mass. (City or Town)

DATE OF BURIAL December 13, 19 62

8 NAME OF FUNERAL DIRECTOR Myron W. Ryder, Jr.

ADDRESS So. Hadley Falls, Mass.

Received and filed DEC 19 1962 19

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 CITIZEN OF U.S.	12
Male	White	YES ☒ NO ☐	SINGLE ☒ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐

12a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

13 DATE OF BIRTH Feb. 23, 1940.

14 AGE 22 Years 9 Months 17 Days — If under 24 hours ... Hours ... Minutes

15 Usual Occupation: Airman - U. S. Air Force (Kind of work done during most of working life)

16 Industry or Business: U. S. A. F.

17 Social Security No. 020-32-2683

18 BIRTHPLACE (City) (State or country) Winthrop, Mass.

PARENTS

19 NAME OF FATHER Edwin H. Blomquist

20 BIRTHPLACE OF FATHER (City) (State or country) Somerville, Mass.

21 MAIDEN NAME OF MOTHER Thelma Stanwood

22 BIRTHPLACE OF MOTHER (City) (State or country) Boston, Mass.

23 Informant Personnel Records
(Address) Westover A.F.B. Mass.

A TRUE COPY.
ATTEST: John T. Brown
(Registrar of City or Town where death occurred)

DATE FILED December 14, 19 62.

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE ....----....

DATE OF DISCHARGE ....December 10, 1962....

RANK, RATING ....A 2/C....

ORGANIZATION AND OUTFIT ....Transportation Sqd.....

SERVICE NUMBER ....AF 11374678....

.....

R-303

r burial permit
d of Health
Agent.

X

1 PLACE OF DEATH: SUFFOLK (County) WINTHROP (City or Town)

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 229

No. 85 Sagamore Avenue, Winthrop St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME WILLIAM SAGAN
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 85 Sagamore Avenue, Winthrop St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December (Month) 14, (Day) 1962 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Acute interstitial pneumonitis.
Pulmonary edema.

5 Accident, suicide, or homicide (specify) .....
Date and hour of injury .....19.....
IF ACCIDENTAL, was injury causally related to the death? .....
Where did Injury occur? ..... (City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)
Manner of Injury ..... (How did injury occur?)
Nature of Injury .....
While at work? ..... Was autopsy performed? Yes.

6 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) Michael A. Luongo, M. D.
Michael A. Luongo, M.D.
(Print or Type Name)
(Address) Boston Date 12/14 19 62

7 TIFERETH ISRAEL- EVERETT
Place of Burial, or Cremation. (City or Town)
DATE OF BURIAL DEC. 14 19 62

8 NAME OF FUNERAL DIRECTOR Benjamin Birnbach
ADDRESS 10 Washington St. Dorchester

Received and filed DEC 14 1962 19.....

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: MALE
10 COLOR: WHITE
11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: SINGLE

12 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

13 DATE OF BIRTH —

14 AGE 0 Years 2 Months 7 Days | If under 24 hours .....Hours .....Minutes

15 Usual Occupation —
(Kind of work done during most of working life)

16 Industry or Business —

17 Social Security No. NONE

18 BIRTHPLACE (City) (State or country) BOSTON, MASS.

PARENTS
19 NAME OF FATHER CHARLES SAGAN
20 BIRTHPLACE OF FATHER (City) (State or country) BOSTON, MASS
21 MAIDEN NAME OF MOTHER PHYLISS GAMERMAN
22 BIRTHPLACE OF MOTHER (City) (State or country) BOSTON, MASS.

23 Informant CHARLES SAGAN
(Address) 85 SAGAMORE AVE, WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Ralph E. Siviano (CHEF)
(Signature of Agent of Board of Health or other)
Health Officer Dec. 14 1962
(Official Designation) (Date of Issue of Permit)

MEDICAL

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50M-9-61-931348

information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poison), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a collision of railroad train and automobile." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic for (enter name of operation and disease or condition requiring surgery)." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

R-301A

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The Commonwealth of Massachusetts

JOSEPH D WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 230

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. Bay View Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Mary W (Kammerer) McDougall (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 390 Winthrop Street St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death years 3 months days. In place of residence 32 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH DEC (Month) 16 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from AUG 9, 1961, to DEC 16, 1962

I last saw h. alive on DEC 16, 1962, death is said to have occurred on the date stated above, at 12 40 P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) GENERAL CARCINOMATOSIS + METASTASIS TO LUNG — INTERVAL BETWEEN ONSET AND DEATH 1 YR.

Due To (b) CARCINOMA OF RT. BREAST — 1 YRS

Due To (c)

OTHER SIGNIFICANT CONDITIONS ARTERIO-SCLEROTIC HEART DS WITH COMPLETE HEART BLOCK — 1 YRS

Was autopsy performed? No

What test confirmed diagnosis? CLINICAL & XRAYS

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Myron N. King, M. D.

MYRON N. KING M.D. (PRINT OR TYPE SIGNATURE)

(Address) 222 PLEASANT ST, WINTHROP 52, MASS Date DEC 17 1962

6 Woodlawn Everett (City or Town)

Place of Burial or Cremation

DATE OF BURIAL Dec. 19 1962

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds

ADDRESS Winthrop Mass

Received and filed DEC 20 1962 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Widow

10a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of William A McDougall (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 87 Years 1 Months 26 Days — If under 24 hours Hours Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: Own Home

15 Social Security No. None

16 BIRTHPLACE (City) Boston (State or country) Mass

PARENTS

17 NAME OF FATHER Christopher Kammerer

18 BIRTHPLACE OF FATHER (City) (State or country) Germany

19 MAIDEN NAME OF MOTHER Mary Baker

20 BIRTHPLACE OF MOTHER (City) Unable to obtain (State or country)

21 Informant Donald McDougall (Address) 390 Winthrop St. Winthrop, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Stevens (Signature of Agent of Board of Health or other)

Health Officer (Official Designation) 12/18/62 (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FRM R-301

or burial permit
Bard of Health
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Registered No. 231

(City or Town making this return)

PLACE OF DEATH
1 Suffolk (County)
Winthrop (City or Town)
No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) NO

2 FULL NAME Bessie ELIZABETH Winston
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 105 Sagamore Avenue St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 44 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Dec. (Month) 18 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ....., 19.50, to Dec. 18, 19.62.
I last saw her alive on Dec. 18, 19.62, death is said to have occurred on the date stated above, at 3:05 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Hypertensive-Coronary Artery Heart Disease — 10 yrs.
Due To
(b)
Due To (c) Cardiac Decompensation — 4 wks.

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS Date 12/18/ 19.62

6 HOLY CROSS MALDEN
Place of Burial or Cremation (City or Town)
DATE OF BURIAL DEC 21 1962

7 NAME OF FUNERAL DIRECTOR MAURICE W KIRBY
ADDRESS WINTHROP

Received and filed DEC 20 1962 19.....
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: FEMALE
9 COLOR: WHITE
10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: SINGLE

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 78 Years.....Months.....Days — If under 24 hours .....Hours.....Minutes

13 Usual Occupation: SEC.
(Kind of work done during most working life)

14 Industry or Business: PILE DRIVING

15 Social Security No. EAST BOSTON

16 BIRTHPLACE (City) EAST BOSTON
(State or country) MASS

PARENTS
17 NAME OF FATHER MICHAEL WINSTON
18 BIRTHPLACE OF FATHER (City) IRELAND
(State or country)
19 MAIDEN NAME OF MOTHER MARY MITCHELL
20 BIRTHPLACE OF MOTHER (City) IRELAND
(State or country)

21 Informant JAMES WINSTON
(Address)
105 SAGAMORE AVE WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Ralph C. Stevens
(Signature of Agent of Board of Health or other)
Health Officer 12/20/62
(Official Designation) (Date of Issue of Permit)

2-932382

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

MR-301A

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The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 232

PLACE OF DEATH

1 Suffolk (County)

Winthrop (City or Town)

No. 82 Plummer Ave. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Julia M. Crowell (First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence, No. 82 Plummer Ave. St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 14 years ..... months ..... days. In place of residence 14 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 19, 1962 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov 6, 1962, to Dec 19, 1962

I last saw her alive on Dec 18, 1962, death is said to have occurred on the date stated above, at 12:45 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH 12/10/62

Due To (b) Arterio Sclerotic Heart Disease — 10 yrs

Due To (c) Arteriosclerosis — 10 yrs

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? Clinical exam

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Louis Scraffa, M. D.
(PRINT OR TYPE SIGNATURE)

(Address) 19 Bennington St Winth Date Dec 19, 1962

6 Place of Burial or Cremation: Holy Cross (City or Town) Malden, Mass

DATE OF BURIAL December 22, 1962

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley

ADDRESS Winthrop, Mass

Received and filed DEC 20 1962 19

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Widowed

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Hiram Crowell
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 81 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: (Retired) ~~Poetry Cook~~
(Kind of work done during most of working life)

14 Industry or Business: ~~Poetry Cook~~ Restaurant

15 Social Security No. 018-18-5063A

16 BIRTHPLACE (City) (State or country) Prince Edward Island

PARENTS

17 NAME OF FATHER Joseph Kennedy

18 BIRTHPLACE OF FATHER (City) (State or country) Newfoundland

19 MAIDEN NAME OF MOTHER Jane Kennedy

20 BIRTHPLACE OF MOTHER (City) (State or country) Newfoundland

21 Informant Harold Crowell
(Address) 82 Plummer Ave. Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Walter E. Sorensen
(Signature of Agent of Board of Health or other)

Health Officer — 12/20/62
(Official Designation) (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FRM R-301

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 233

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Laura M. (Shea) McGrath
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 35 Lincoln St., St. Winthrop Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.
1 hour 30 min.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH DEC (Month) 19 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 12/12, 1962, to 12/19, 1962
I last saw he alive on 12/19/62, 19....., death is said to have occurred on the date stated above, at 5:20 p.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

	INTERVAL BETWEEN ONSET AND DEATH
(a) CEREBRAL HEMORRHAGE	
Due To (b) LEFT HEMIPLEGIA	2½ hrs
Due To (c) HYPERTENSIVE HEART DIS	1 YR
OTHER SIGNIFICANT CONDITIONS NONE	

Was autopsy performed? No
What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Myron N. King, M. D.
MYRON N. KING, M.D.
(Print or Type Name)
(Address) 222 Pleasant St. Winthrop Mass. Date 12/19/1962

6 Winthrop Cemetery, Winthrop
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Dec. 22, 1962

7 NAME OF FUNERAL DIRECTOR Ernest A. Cassiano
ADDRESS 147 Winthrop St., Winthrop

Received and filed DEC 21 1962 19.....
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: female
9 COLOR: white
10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: married

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Michael D. McGrath
(Husband's name in full)

12 AGE 55 Years 7 Months 23 Days | If under 24 hours .....Hours.....Minutes

13 Usual Occupation Housewife
(Kind of work done during most working life)

14 Industry or Business: at home

15 Social Security No. 029-10-6933

16 BIRTHPLACE (City) Cohasset
(State or country) Mass.

PARENTS
17 NAME OF FATHER John J. Shea
18 BIRTHPLACE OF FATHER (City) Connecticut
(State or country)
19 MAIDEN NAME OF MOTHER Catherine Greeley
20 BIRTHPLACE OF MOTHER (City)
(State or country) Ireland

21 Informant Michael D. McGrath
(Address) 35 Lincoln St.
Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Ralph E. Sessamis
(Signature of Agent of Board of Health or other)
Health Officer 12/21/62
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

DRM R-301

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INSTRUCTIONS FOR ICA CERTIFICATE

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 234

PLACE OF DEATH

1 Suffolk (County) Somerville 1-7-63

Winthrop (City or Town)

No. Winthrop Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Eva Lotti Dini (LOTTI)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 15 Bailey Road St. Somerville
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months. 3 days. In place of residence 12 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 12 (Month) 22 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 12-19, 1962, to 12-22, 1962

I last saw h. alive on 12-21, 1962, death is said to have occurred on the date stated above, at 2:15 a.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS: Cardiac Hypertrophy (4 years) — YRS.

Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify

(Signature) John D. Latorella, M. D.
John D. Latorella
(Print or Type Name)

(Address) 305 Chelsea St. Date 12/22 1962

6 Holy Cross Malden
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Dec-24- 1962

7 NAME OF FUNERAL DIRECTOR Arthur S. Barcella

ADDRESS 876 Winthrop Ave. Revere

Received and filed DEC 26 1962 19.....

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: F

9 COLOR: white

10 SINGLE (write the word) MARRIED WIDOWED widow DIVORCED UNKNOWN

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Guiseppe Dini
(Husband's name in full)

12 AGE 62 Years 5 Months — Days — If under 24 hours .....Hours.....Minutes

13 Usual Occupation: At home
(Kind of work done during most working life)

14 Industry or Business:

15 Social Security No. None

16 BIRTHPLACE (City) Italy
(State or country)

PARENTS

17 NAME OF FATHER Dario Frsso - Lotti

18 BIRTHPLACE OF FATHER (City).....
(State or country) Italy

19 MAIDEN NAME OF MOTHER Marianna Padrini

20 BIRTHPLACE OF MOTHER (City).....
(State or country) Italy

21 Informant Mrs Julia Dini
(Address)
726 Saratoga St. E. Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit)

2-932382

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a fatal illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

MR-301A

STICTIONS
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Chapter 137,
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100M-11-55-916145

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 235

1 PLACE OF DEATH
SUFFOLK (County)
WINTHROP (City or Town)
No. 24 FORREST ST. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME James A Mills
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Residence. No. 24 Forrest St St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 2 years months 2 days. In place of residence 2 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December (Month) 22 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from —, 19—, to —, 19—
I last saw h— alive on —, 19—, death is said to have occurred on the date stated above, at 4:50 P. m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Natural Causes — INTERVAL BETWEEN ONSET AND DEATH

Due To (b) Cerebral Palsy — 3 yrs

Due To (c) (Congenital)

OTHER SIGNIFICANT CONDITIONS —

Was autopsy performed? no
What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) Arthur C. Murray, M. D.
Winthrop Board of Health Date 23 Dec 1962

6 Winthrop WINTHROP
Place of Burial or Cremation (City or Town)
DATE OF BURIAL DEC 24 1962

7 NAME OF FUNERAL DIRECTOR Maurice W Tuky
ADDRESS WINTHROP

Received and filed DEC 26 1962 19
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX MALE
9 COLOR WHITE
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) SINGLE

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 3 Years 6 Months Days — If under 24 hours Hours Minutes

13 Usual Occupation: NONE
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) Oxley
(State or country) China

PARENTS

17 NAME OF FATHER Robert P Mills

18 BIRTHPLACE OF FATHER (City) Sayre
(State or country) Penn

19 MAIDEN NAME OF MOTHER Mildred E Shaul

20 BIRTHPLACE OF MOTHER (City) Reading
(State or country) Penn.

21 Informant ROBERT MILLS
(Address) 24 FORREST ST.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Simmons
(Signature of Agent of Board of Health or other)

M.O. (Official Designation) Dec. 24, 1962 (Date of Issue of Permit)

EXTRACTS

FROM THE LAWS OF THE

COMMONWEALTH OF MASSACHUSETTS

GOVERNING THE

RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . .Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourte n, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead. .. — General Laws, Chap. 38, Sec. 6., as amended by Chap. 632, Sec. 4, Acts of 1945.

No undertaker or other persons shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made.
. . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE .....

DATE OF DISCHARGE .....

RANK, RATING .....

ORGANIZATION AND OUTFIT .....

SERVICE NUMBER .....

.....

FRM R-301

...or burial permit
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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

WINTHROP
(City or Town making this return)

Registered No. 236

1 PLACE OF DEATH
Suffolk (County)
Winthrop (City or Town)
No. Winthrop Community Hosp. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Gabriel Girla
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 41 Upland Rd St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months....1....days. In place of residence....45....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Dec. (Month) 23 (Day) 1962 (Year)

4 I HEREBY CERTIFY That I attended deceased from Dec. 20, 1962, to Dec. 23, 1962
I last saw him alive on Dec. 23, 1962, death is said to have occurred on the date stated above, at 1:15 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Cerebrovascular Hemorrhage — 3 days.
Due To (b) Cerebral Arteriosclerosis — 2 wks
Due To (c)

OTHER SIGNIFICANT CONDITIONS None

Was autopsy performed? No
What test confirmed diagnosis? Clinical

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Charles Liberman, M. D.
CHARLES LIBERMAN
(Print or Type Name)
(Address) WINTHROP, MASS. Date 12/23/1962

6 Place of Burial or Cremation Holy Cross Cem. Malden (City or Town)
DATE OF BURIAL December 27 1962

7 NAME OF FUNERAL DIRECTOR Bourgeois Paul
ADDRESS 128 Revere St Revere

Received and filed DEC 26 1962 19....
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN: Married

11 If married, widowed, or divorced
HUSBAND of Clarence Di Orsa
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 77 Years — Months — Days | If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Retired
(Kind of work done during most working life)

14 Industry or Business: Tailor

15 Social Security No. 021-09-0103

16 BIRTHPLACE (City) Italy
(State or country)

PARENTS

17 NAME OF FATHER Ciriaco Girla
18 BIRTHPLACE OF FATHER (City) Italy
(State or country)
19 MAIDEN NAME OF MOTHER Cannot be learned
20 BIRTHPLACE OF MOTHER (City) Italy
(State or country)

21 Informant Mrs Florence Girla
(Address)
41 Upland Rd Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Ralph C. Sullivan
(Signature of Agent of Board of Health or other)
Health Officer 12/26/62
(Official Designation) (Date of Issue of Permit)

2-932382

A TRUE COPY ATTEST:

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

R-301A

NSTRUCTIONS FOR CERTIFICATE

giving S OF DEATH

do not enter than one for each (b) and (c)

does not mean of dying, heart failure, etc. It means ive, or compli- which caused

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M. C.

Chapter 137, 954, requires ns to print or e cause or of death on tificates, and 48, Acts of quires Physi- print or type der signature.

11-59-926662

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 237

1 PLACE OF DEATH: SUFFOLK (County) — WINTHROP (City or Town) — No. 234 COURT RD St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: JOSEPH W NOLAN (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR): NO

(a) Residence. No. 234 COURT RD St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 43 years ... months ... days. In place of residence 43 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: December (Month) 23 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from ——, 19—, to ——, 19—

I last saw h— alive on ——, 19—, death is said to have occurred on the date stated above, at 1:15 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) Natural Causes —

Due To (b) Presumably Coronary Occlusion — sudden

Due To (c) Arteriosclerotic Heart Disease — 10 yrs.

OTHER SIGNIFICANT CONDITIONS: none —

Was autopsy performed? no

What test confirmed diagnosis? post-mortem judgement

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Arthur C. Murray M. D.

Arthur C. Murray (PRINT OR TYPE SIGNATURE)

Address Winthrop Board of Health Date 24 Dec 1962

6 WINTHROP (Place of Burial or Cremation) WINTHROP (City or Town)

DATE OF BURIAL DEC 26 1962

7 NAME OF FUNERAL DIRECTOR: MAURICE W KIRBY

ADDRESS: WINTHROP

Received and filed DEC 26 1962 19—

(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: MALE

9 COLOR: WHITE

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): MARRIED

10a If married, widowed, or divorced HUSBAND of RUTH H ECKD (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 49 Years ... Months ... Days — If under 24 hours ... Hours ... Minutes

13 Usual Occupation: AIR LINES (Kind of work done during most of working life)

14 Industry or Business: FREIGHT DISPATCHER

15 Social Security No.

16 BIRTHPLACE (City) EAST BOSTON (State or country) MASS

PARENTS

17 NAME OF FATHER: JOSEPH W NOLAN

18 BIRTHPLACE OF FATHER (City) BOSTON (State or country) MASS

19 MAIDEN NAME OF MOTHER: SARAH McDERMOTT

20 BIRTHPLACE OF MOTHER (City) BOSTON (State or country) MASS

21 Informant RUTH H NOLAN (Address) 234 COURT RD WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Ralph E. Simmons (Signature of Agent of Board of Health or other)

K. O. (Official Designation) Dec 29 1962 (Date of Issue of Permit)

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Physicians: see explanatory instructions on face side of standard certificate of death.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed, or if the deceased had retired from business, report the kind of work done during most of working life even if retired. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

FORM R-301

let or burial permit
Board of Health
or's Agent.

INSTRUCTIONS
FOR
CATE CERTIFICATE

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Director
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2-2-932382

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

OUT - OF - TOWN
(City or Town making the return)

STANDARD CERTIFICATE OF DEATH

Registered No. 238

PLACE OF DEATH

X SUFFOLK (County)

1 BOSTON (City or Town)

No. MASSACHUSETTS GENERAL HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Brian E. Riggs (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR). NO

(a) Residence, No. 40 Sunset Road (Usual place of abode) St. Winthrop, Massachusetts (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 2 years 1 months 27 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 27, 1962 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept. 26, 1962 to Oct. 27, 1962

I last saw him alive on Oct. 27, 1962 death is said to have occurred on the date stated above, at 12:58a m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) BRONCHOPNEUMONIA BILATERAL — INTERVAL BETWEEN ONSET AND DEATH: 7 DAS.

Due To (b) BRAIN ABSCESS — I½ Yrs.

Due To (c)

OTHER SIGNIFICANT CONDITIONS HYDROCEPHALUS — I½ YRS.

Was autopsy performed? YES

What test confirmed diagnosis? AUTOPSY

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signature) C. L. Clay, M. D.

Charles L. Clay, M. D. (Print or Type Name)

(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date OCT 27 1962

6 WINTHROP Place of Burial or Cremation WINTHROP (City or Town)

DATE OF BURIAL OCT 30 1962

7 NAME OF FUNERAL DIRECTOR MAURICE W. KIRBY

ADDRESS WINTHROP

Received and filed OCT 31 1962

Charles H. Mackie (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: MALE

9 COLOR: WHITE

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): SINGLE

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 AGE 2 Years 1 Months 27 Days. If under 24 hours Hours Minutes

13 Usual Occupation: NONE (Kind of work done during most working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) WINTHROP (State or country) MASS

PARENTS

17 NAME OF FATHER EDWARD J RIGGS

18 BIRTHPLACE OF FATHER (City) BOSTON (State or country) MASS

19 MAIDEN NAME OF MOTHER JUDITH REESE

20 BIRTHPLACE OF MOTHER (City) BOSTON (State or country) MASS

21 Informant EDWARD J RIGGS (Address) 40 SUNSET RD WINTHROP.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

B13530 (Official Designation) 10-29-62 (Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

FORM R-301

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The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT OF TOWN 239

(City or Town making this return)

Registered No. .....

PLACE OF DEATH

1 Suffolk (County)

Boston (City or Town)

GLENSIDE HOSPITAL No. ..... St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME CARROLL, Mary A. (nee Reardon)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 18 Wadsworth Ave St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 0 years 0 months 44 days. In place of residence 35 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October (Month) 31 (Day) 1962 (Year)

4 I HEREBY CERTIFY That I attended deceased from 9-17-62, 19.. to 10-31, 1962, 19.. I last saw her alive on 10-31, 1962, 19.. death is said to have occurred on the date stated above, at 12.30 P.M.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Pulmonary embolus — INTERVAL BETWEEN ONSET AND DEATH: 4 hr.

Due To (b) Blood clot, site unknown — unk.

Due To (c) — yrs.

OTHER SIGNIFICANT CONDITIONS Generalized arterio-sclerosis with chronic brain syndrome

Was autopsy performed? no

What test confirmed diagnosis? Phys. Exam.

5 Was disease or injury in any way related to occupation of deceased? ..... If so, specify .....

(Signature) Donald P. Barker, M.D., M. D.

DONALD P. BARKER M.D.
(Print or Type Name)

(Address) GLENSIDE HOSPITAL J. Plain Mass. Date 10-31-62, 19..

6 Place of Burial or Cremation Calvary (City or Town) Brockton Mass

DATE OF BURIAL Nov 3, 19 62

7 NAME OF FUNERAL DIRECTOR Ernest P. Beggrans

ADDRESS 147 Winthrop St Winthrop

Received and filed NOV 6 1962, 19.. Charles H. Mackie (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Patrick J. Carroll
(Husband's name in full)

12 AGE 87 Years ..... Months ..... Days. If under 24 hours: Hours ..... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most working life)

14 Industry or Business: at Home

15 Social Security No. .....

16 BIRTHPLACE (City) (State or country) Ireland

PARENTS

17 NAME OF FATHER Jeremiah Reardon

18 BIRTHPLACE OF FATHER (City) (State or country) Ireland

19 MAIDEN NAME OF MOTHER Catherine McCarthy

20 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

21 Informant John Carroll
(Address) 44 W. Eagle St East Boston

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

R. K. Gannon
(Signature of Agent of Board of Health or other)

B13601 (Official Designation) 11-2-62 (Date of Issue of Permit)

OM R-301

burial permit
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TRITIONS
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CERTIFICATE

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1 - 1963

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

240

OUT-OF-TOWN

(City or Town making this return)

Registered No. 11408

PLACE OF DEATH

1 Suffolk (County)

Boston (City or Town)

No. Veterans Administration Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Joseph Harold GAHM
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) WWI

(a) Residence. No. 929 Shirley St. Winthrop, Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 0 years 1 months 16 days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November (Month) 21 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Oct 5, 1962, to Nov 21, 1962, death is said to have occurred on the date stated above, at 4:15A m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

	INTERVAL BETWEEN ONSET AND DEATH
(a) Renal Failure secondary to Renal nephrosis	days
Due To (b) Status post-op abdominal aneurysm resection	4 days
Due To (c) Status post-op Tur of Bladder papilloma	15 days
OTHER SIGNIFICANT CONDITIONS Post-op sigmoid resection for Diverticulitis	mos

Was autopsy performed? Yes
What test confirmed diagnosis? Autopsy & lab findings

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signature) J. Peter Macelli, M. D.
J. Peter Macelli M.D.
(Print or Type Name)
(Address) VAH Boston, Mass Date Nov 21 1962

6 Mt. Pleasant Cem. Arlington, Mass
Place of Burial or Cremation (City or Town)
DATE OF BURIAL 11-24-62 19

7 NAME OF FUNERAL DIRECTOR Morris Kirby F.H.
ADDRESS 210 Winthrop St., Winthrop, Mass.

Received and filed NOV 27 1962 19
Charles H. MacKee
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE / MARRIED / WIDOWED / DIVORCED / UNKNOWN (write the word): Married

11 If married, widowed, or divorced
HUSBAND of Margaret M. Carthy
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 AGE 65 Years 8 Months 8 Days
If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Retired clerk
(Kind of work done during most working life)

14 Industry or Business: .....

15 Social Security No. 012 07 4261

16 BIRTHPLACE (City) Somerville
(State or country) Mass

PARENTS

17 NAME OF FATHER: Joseph S. Gahm

18 BIRTHPLACE OF FATHER (City) Charlestown,
(State or country) Mass

19 MAIDEN NAME OF MOTHER: Catherine Sullivan

20 BIRTHPLACE OF MOTHER (City) E. Cambridge,
(State or country) Mass.

21 Informant (Address) V.A. Hosp. Records 150 South Huntington Ave., Boston, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

13400 11/21/62
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

RECEIVED

FEB 1 1963 AM

FORM R-302

WRITE PLAINLY, WITH UNFADING BLACK INK. THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

X

472

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Revere
(City or Town making this return)

Registered No. 241

PLACE OF DEATH

1 County: Suffolk

City or Town: Revere

No. Grover Manor Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: Margaret McLeod
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR,

(a) Residence. No. 4 Pleasant St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 9 years 16 days. In place of residence 51 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December (Month) 14, (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb. 28, 1962, to Dec. 14, 1962

I last saw him alive on Dec. 14, 1962 death is said to have occurred on the date stated above, at 8:00P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2days

Due To (b) Cerebral Vascular Accident — 1year

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no

What test confirmed diagnosis? Clinical Signs

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) James F. Burns, M. D.

(Address) Everett, Mass. Date 12/14/ 1962

6 Place of Burial or Cremation: Winthrop Cemetery, Winthrop (City or Town)

DATE OF BURIAL December 18, 1962

7 NAME OF FUNERAL DIRECTOR: Arthur J. O'Maley

ADDRESS: Winthrop, Mass.

Received and filed JAN 15 1963 19

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Single

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

12 AGE 69 Years Months Days — If under 24 hours Hours Minutes

13 Usual Occupation: Secretary
(Kind of work done during most working life)

14 Industry or Business: Ludlow Valve

15 Social Security No. 032-05-1423A

16 BIRTHPLACE (City) Boston (State or country) Mass.

PARENTS

17 NAME OF FATHER: George McLeod

18 BIRTHPLACE OF FATHER (City) North Sydney (State or country) Cape Breton, N. S.

19 MAIDEN NAME OF MOTHER: Mary A. McArthur

20 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

21 Informant: Charlotte McLeod
(Address) 4 Pleasant St., Winthrop

A TRUE COPY
ATTEST: Joseph A. Sheehan
(Registrar of City or Town where death occurred)

DATE FILED December 18, 1962

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

FORM R-302

473

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Revere
(City or Town making this return)

Registered No. 242

1 PLACE OF DEATH
Suffolk (County)
Revere (City or Town)
No. Grover Manor Hospital xx (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary G. Fanning (Sullivan)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR,

(a) Residence. No. 31 River Road x Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months 10 days. In place of residence 40 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December (Month) 15, (Day) 1962 (Year)

4 I HEREBY CERTIFY. That I attended deceased from Dec. 5, 1962, to Dec. 15, 1962
I last saw he alive on Dec. 15, 1962, death is said to have occurred on the date stated above, at 8:00P m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2days
Due To (b) Cerebral vascular accident — 3wks.
Due To (c)
OTHER SIGNIFICANT CONDITIONS

Was autopsy performed? no
What test confirmed diagnosis? Clinical Signs

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) James F. Burns, M. D.
(Address) Everett, Mass. Date 12/15/ 62

6 Holy Cross Malden
Place of Burial or Cremation (City or Town)
DATE OF BURIAL December 18, 1962

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Maley
ADDRESS Winthrop, Mass.

Received and filed JAN 15 1963 19....
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female
9 COLOR: White
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word): Widowed

11 If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of William F. Fanning
(Husband's name in full)

12 AGE 82 Years....Months....Days — If under 24 hours ....Hours....Minutes

13 Usual Occupation: Housewife
(Kind of work done during most working life)

14 Industry or Business: Own Home

15 Social Security No.

16 BIRTHPLACE (City) Boston (State or country) Mass.

PARENTS
17 NAME OF FATHER John Sullivan
18 BIRTHPLACE OF FATHER (City) Boston (State or country) Mass.
19 MAIDEN NAME OF MOTHER Esther Roe
20 BIRTHPLACE OF MOTHER (City) Boston (State or country) Mass.

21 Informant Florence Caspole
(Address) 31 River Road, Winthrop

A TRUE COPY
ATTEST: Joseph F. Wolcott
(Registrar of City or Town where death occurred)
DATE FILED December 18, 1962

WRITE PLAINLY, WITH UNFADING BLACK INK. THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible, after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50M-10-61-931673

m. c.

SPACE FOR ADDITIONAL INFORMATION .....

DATE OF ENTERING MILITARY SERVICE.....

DATE OF DISCHARGE.....

RANK, RATING .....

ORGANIZATION AND OUTFIT.....

SERVICE NUMBER.....

.....

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Quincy
(City or town making return)

Registered No. 1029 243

PLACE OF DEATH

1 Norfolk (County)

Quincy (City or Town)

No. Quincy City Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Joseph F. Dever, Jr. (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) W.W.2

(a) Residence. No. 44 Wilshire Street St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death — years — months 1 days. In place of residence 1 years — months — days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December (Month) 27, (Day) 1962 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Presumably coronary occlusion.
Died suddenly.

5 Accident, suicide, or homicide (specify)
Date and hour of injury 19
If accidental, was injury causally related to the death?
Where did Injury occur? (City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)
Manner of Injury (How did injury occur?)
Nature of Injury
While at work? Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Frederic Tudor, M. D.
(Address) Milton, Mass. Date 12/27 19 62

7 Winthrop Cemetery, Winthrop, Mass.
Place of Burial or Cremation. (City or Town)
DATE OF BURIAL Dec. 31, 19 62

8 NAME OF FUNERAL DIRECTOR Maurice W. Kirby
ADDRESS Winthrop, Mass.

Received and filed JAN 16 1963 ~~Dec. 28,~~ 19 62
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR	11 CITIZEN OF U.S.	12 SINGLE ☐ MARRIED ☒ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐
Male	White	YES ☐ NO ☐	

12a If married, widowed, or divorced
HUSBAND of Helen G. Fuller (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

13 DATE OF BIRTH

14 AGE 38 Years — Months — Days | If under 24 hours Hours Minutes

15 Usual Occupation: Insurance Agent (Kind of work done during most of working life)

16 Industry or Business: Life Insurance

17 Social Security No. —

18 BIRTHPLACE (City) Boston (State or country) Mass.

PARENTS

19 NAME OF FATHER Joseph F. Dever

20 BIRTHPLACE OF FATHER (City) Boston (State or country) Mass.

21 MAIDEN NAME OF MOTHER Marion G. Clifford

22 BIRTHPLACE OF MOTHER (City) Boston (State or country) Mass.

23 Informant Mrs. Joseph F. Dever, Jr.
(Address) 44 Wilshire St., Winthrop, Mass.

A TRUE COPY.
ATTEST: [signature]
(Registrar of City or Town where death occurred)

DATE FILED 19

M .-305

WRITE LEGIBLY, WITH INDELIBLE INK. THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-3-61-930213

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE September 9, 1942

DATE OF DISCHARGE October 23, 1945

RANK, RATING T/Sgt.

ORGANIZATION AND OUTFIT 11067643

SERVICE NUMBER

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

244

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH
Suffolk (County)
Boston (City or Town)
No. The Children's Hospital Medical Ctr. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Steven Mark Coler
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) NO

(a) Residence. No. 100 Circuit Rd. St. Winthrop
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 23 hrs. 40 min. years months days. In place of residence 14 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. 29, 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 28, 1962, to Nov. 29, 1962
I last saw him alive on Nov. 29, 1962, death is said to have occurred on the date stated above, at 12:10 pm

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) Leukemia (Acute)
Due To (b)
Due To (c)
OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH 1/2 year

Was autopsy performed? Yes
What test confirmed diagnosis? Bone Marrow

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....

(Signed) DINAH KOHNER M. D.
Dinah Kohner
(Print or Type Name)
(Address) 300 Longwood Ave Date 11-29-62

6 Sharon Memorial Park Sharon
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Nov 30 1962

7 NAME OF FUNERAL DIRECTOR Morris W. Breznik
ADDRESS 470 Harvard St. Brookline

Received and filed DEC 4 1962 19..
Charles A. Mackie
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR	10 CITIZEN OF U.S.	11 SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ UNKNOWN ☐
MALE	White	YES ☐ NO ☐	

11a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 DATE OF BIRTH

13 AGE 14 Years ..... Months ..... Days — If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: STUDENT
(Kind of work done during most of working life)

15 Industry or Business: STUDENT

16 Social Security No. NONE

17 BIRTHPLACE (City) (State or country) WINTHROP

PARENTS
18 NAME OF FATHER NORMAN S. COLOR
19 BIRTHPLACE OF FATHER (City) (State or country) NEW YORK, N.Y.
20 MAIDEN NAME OF MOTHER JEANNE GOLOBOY
21 BIRTHPLACE OF MOTHER (City) (State or country) RUSSIA

22 Informant NORMAN S. COLER
(Address) 100 CIRCUIT Rd., WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Jacqueline Dorato
(Signature of Agent of Board of Health or other)
(Official Designation) (Date of Issue of Permit)

A TRUE COPY ATTEST:

[illegible]

[illegible]

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

245

STANDARD CERTIFICATE OF DEATH

(City or Town making this return)

Registered No. 44[illegible]

PLACE OF DEATH

1 Suffolk (County)

Boston (City or Town)

x Veterans Administration Hospital x (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Edward J. Cox
(If deceased is a married, widowed or divorced woman, give also maiden name)

(Was deceased a U. S. War Veteran, (if so specify WAR) WWII

(a) Residence. No. 16 Wilshire St. Winthrop, Mass.
(Usual place of abode) (City or town and State)

Length of stay: In place of death ..... years ..... months 23 days. In place of residence 16 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December (Month) 4 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 11, 1962, to Dec. 4, 1962 VA, death is said to have occurred on the date stated above, at 2:00P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Carcinoma of left lung with metastases to lymph nodes.

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH: 7 Mths

Was autopsy performed? Yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? ..... If so, specify .....

(Signature) Roger Daniels, M. D.

Roger Daniels
(Print or Type Name)

(Address) VAH, Boston, Mass. Date 12-4-1962

6 Winthrop Cemetery Winthrop, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 7, 1962

7 NAME OF FUNERAL DIRECTOR Morris Kirby

ADDRESS 210 Winthrop St Winthrop, Mass.

Received and filed DEC 7 1962

Charles H. Mackie (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR: White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word): Married

11 If married, widowed, or divorced
HUSBAND of Sarah Bradeen
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

12 AGE 62 Years 0 Months 4 Days | If under 24 hours: Hours ..... Minutes

13 Usual Occupation: Lineman
(Kind of work done during most of working life)

14 Industry or Business: WESTERN UNION

15 Social Security No. 010-07-0223

16 BIRTHPLACE (City) Newton (State or country) Mass.

PARENTS

17 NAME OF FATHER: Joseph Cox

18 BIRTHPLACE OF FATHER (City) ..... (State or country) Ireland

19 MAIDEN NAME OF MOTHER: Julia McDonell

20 BIRTHPLACE OF MOTHER (City) ..... (State or country) Ireland

21 Informant: V.A. Hospital Records, 150 S.
(Address) Huntington Ave., Boston, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

R. R. Gannon
(Signature of Agent of Board of Health or other)

B14142 (Official Designation) 12-6-62 (Date of Issue of Permit)

FORM R-301

for burial permit and Health ts agent.

TRUCTIONS FOR CERTIFICATE

TYPE OF CAUSES DEATH

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do not mean of dying, but failure. It means or complication caused

if any, give rise to use (a), the underlying cause last.

tions contributing death but not the terminal condition given

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The Commonwealth of Massachusetts

246

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

PLACE OF DEATH

1 SUFFOLK (County)

BOSTON (City or Town)

(City or Town making this return) CITY OF TOWN

Registered No.

No. New England Center Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Mrs Ethel R Sullivan (Kelly)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify W.AR.) no

(a) Residence. No. 63 Thornton Park St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months. 2 days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 7 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased, from ....., 19..... to ....., 19..... I last saw ..... alive on ....., 19..., death is said to have occurred on the date stated above, at ..... m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE

(a) Amyotrophic Lateral Sclerosis

INTERVAL BETWEEN ONSET AND DEATH 7 yrs

Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS L Lung Atelectasis

Was autopsy performed? NO

What test confirmed diagnosis? EXAMINATION ONLY

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signature) Alan R. Schwartz, M. D.
ALAN R. SCHWARTZ
(Print or Type Name)
(Address) NEEH., Boston Date 12/7/1962

6 Winthrop Cemetery, Winthrop
Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 10, 1962

7 NAME OF FUNERAL DIRECTOR Ernest P. Caggiano
ADDRESS 147 Winthrop St., Winthrop

Received and filed DEC 11 1962, 19...
Charles H. Mackie
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female

9 COLOR White

10 SINGLE, MARRIED, WIDOWED, DIVORCED, UNKNOWN (write the word) married

11 If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Francis J. Sullivan
(Husband's name in full)

12 AGE 47 Years 11 Months ..... Days | If under 24 hours Hours.....Minutes

13 Usual Occupation Housewife
(Kind of work done during most working life)

14 Industry or Business: at home

15 Social Security No.

16 BIRTHPLACE (City) Winthrop
(State or country) Mass.

PARENTS

17 NAME OF FATHER John L. Kelly

18 BIRTHPLACE OF FATHER (City) Boston
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Ethel Boyle

20 BIRTHPLACE OF MOTHER (City).....
(State or country) Pennsylvania

21 Informant Francis J. Sullivan
(Address)
63 Thornton Pk., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or Transit permit was issued:
Stephen Zoman B.S.C.E.C.
(Signature of Agent of Board of Health or other)
(Official Designation) Dec 9 1962
(Date of Issue of Permit).

ORI R-301

for burial permit
and Health
agent.

INSTRUCTIONS FOR CERTIFICATE

TYPE OR CAUSES DEATH

enter this one of each (band (e)

does not mean of dying, but failure. It means or complications caused

if any, give rise to (a), under-lying last.

contributed but not the terminal tion given

56.1
78

12 1963

-932382

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

The Commonwealth of Massachusetts

KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Registered No. 12139

(City or Town making this return) BOSTON 247

1 PLACE OF DEATH
SUFFOLK (County)
BOSTON (City or Town)
No. MASSACHUSETTS GENERAL HOSPITAL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

2 FULL NAME MILDRED I EVANS (Eldredge)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 20 Enfield Rd. St. Winthrop, Massachusetts
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..years ..months 4 days. In place of residence 60 years 9 months ..days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December (Month) 11 (Day) 1962 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec. 7, 1962, to December 11, 1962
I last saw her alive on December 11, 1962, death is said to have occurred on the date stated above, at 12:40pm.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE	INTERVAL BETWEEN ONSET AND DEATH
(a) Intestinal Obstruction	24 hrs
Due To (b) Small Bowel Volvulus	24 hrs
Due To (c) Peritoneal Adhesions	years
OTHER SIGNIFICANT CONDITIONS Cystadenoma of Ovary	Years

Was autopsy performed? Yes
What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? ..
If so, specify ..

(Signature) C. Clay, M. D.
Charles L. Clay, M.D. (Print or Type Name)
(Address) Ass't. Dir., Mass. Gen'l. Hosp. Date Dec. 11 1962

6 Winthrop Winthrop
Place of Burial or Cremation (City or Town)
DATE OF BURIAL December 14 1962

7 NAME OF FUNERAL DIRECTOR Howard S Reynolds
ADDRESS Winthrop, Mass

Received and filed DEC 14 1962 19..
Charles H. Mackie
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female
9 COLOR White
10 SINGLE MARRIED WIDOWED DIVORCED UNKNOWN (write the word) Married

11 If married, widowed, or divorced
HUSBAND of ..
(Give maiden name of wife in full)
(or) WIFE of Harold J Evans
(Husband's name in full)

12 AGE 60 Years 9 Months 0 Days
If under 24 hours ..Hours ..Minutes

13 Usual Occupation: Housewife
(Kind of work done during most working life)

14 Industry or Business: Own home

15 Social Security No. none

16 BIRTHPLACE (City) Winthrop
(State or country) Mass.

PARENTS

17 NAME OF FATHER Sam Eldredge

18 BIRTHPLACE OF FATHER (City) ..
(State or country) China

19 MAIDEN NAME OF MOTHER Hattie Brown

20 BIRTHPLACE OF MOTHER (City) Boston
(State or country) Mass.

21 Informant Harold J Evans
(Address) 20 Enfield Rd. Winthrop, Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
E. J. Rogerson M.D.
(Signature of Agent of Board of Health or other)
Bkt 229 12-13-62
(Official Designation) (Date of Issue of Permit)

DECLINED BY MEDICAL EXAMINER

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

X

248

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 12331

1 PLACE OF DEATH
Suffolk (County)
Boston (City or Town)
No. 321 Princeton Street St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Frederick W. Laidlaw
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence, No. 177 Somerset Ave., St. Winthrop, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death years 8 months days. In place of residence 12 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 16, 1962
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from FEB 4, 1957, to DEC 16, 1962
I last saw him alive on , 19, death is said to have occurred on the date stated above, at 9.20 P.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE — INTERVAL BETWEEN ONSET AND DEATH

(a) CEREBRAL VASCULAR ACCIDENT — 1 DAYS
Due To (b) HYPERTENSIVE AND ARTERIO-SCLEROTIC HEART DS — 10 YRS
Due To (c) GENERAL ARTERIOSCLEROSIS — 10 YRS
OTHER SIGNIFICANT CONDITIONS OLD CEREBRAL WITH PARTIAL PARALYSIS — 10 YRS

Was autopsy performed? No
What test confirmed diagnosis? CLINICAL

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Myron N. King, M. D.
MYRON N. KING M.D.
(PLEASE PRINT OR TYPE SIGNATURE)
(Address) WINTHROP, MASS Date 12/17 1962

6 Holy Cross Malden, Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 20 1962

7 NAME OF FUNERAL DIRECTOR Arthur J. O'Malley
ADDRESS Winthrop, Mass

Received and filed DEC 21 1962 19

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male
9 COLOR: White
10 SINGLE, MARRIED, WIDOWED, or DIVORCED (write the word): Widowed

10a If married, widowed, or divorced
HUSBAND of Lillian J. Johnson
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 75 Years Months Days — If under 24 hours Hours Minutes

13 Usual Occupation: Retired Painter
(Kind of work done during most of working life)

14 Industry or Business: M. T. A.

15 Social Security No. 031-05-5371

16 BIRTHPLACE (City) Lowell
(State or country) Mass

PARENTS

17 NAME OF FATHER William H. Laidlaw

18 BIRTHPLACE OF FATHER (City)
(State or country) Nova Scotia

19 MAIDEN NAME OF MOTHER Annie Christopher

20 BIRTHPLACE OF MOTHER (City)
(State or country) Newfoundland

21 Informant Loretta Gallagher
(Address) 177 Somerset Ave., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
J. Dordo
(Signature of Agent of Board of Health or other)
B 4315 12/18/62

A TRUE COPY ATTEST:

Cornelius H. Mackie

City Registrar

249

The Commonwealth of Massachusetts

JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

OUT - OF - TOWN
To be filed for burial permit with Board of Health or Agent

Registered No. 12624

1 PLACE OF DEATH
County: SUFFOLK
City or Town: BOSTON
No. ST. ELIZABETH HOSP St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) NO

2 FULL NAME TIRRELL E. HENRY
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence No. 230 SHORE DR. St. WINTHROP
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death years months 2 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 12 (Month) 26 (Day) 62 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 12/26, 1962 to 12/26, 1962
I last saw him alive on 12/26, 1962, death is said to have occurred on the date stated above, at 9:00 A.m.

DEATH WAS CAUSED BY: IMMEDIATE CAUSE
(a) ACUTE PULMONARY EDEMA
Due To (b) A.S.N.D. arterio sclerotic heart disease
Due To (c) MYOCARDIAL INFARCT
OTHER SIGNIFICANT CONDITIONS

INTERVAL BETWEEN ONSET AND DEATH

Was autopsy performed? No.
What test confirmed diagnosis? No.

5 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Thomas J. Connolly, M. D.
THOMAS J. CONNOLLY
(PRINT OR TYPE SIGNATURE)
(Address) St. E's Hosp Date 12/26, 1962

6 WINTHROP Place of Burial or Cremation WINTHROP (City or Town)
DATE OF BURIAL DEC 29, 1962

7 NAME OF FUNERAL DIRECTOR MAURICE W. KIRBY
ADDRESS WINTHROP

Received and filed DEC 28 1962
Charles F. Mackie

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: MALE
9 COLOR: WHITE
10 SINGLE MARRIED WIDOWED or DIVORCED (write the word): MARRIED

10a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of ALICE E. HARRINGTON
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 74 Years Months Days
If under 24 hours Hours Minutes

13 Usual Occupation: B.E. Fel. Tel.
(Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. 011-07-7657

16 BIRTHPLACE (City) BOSTON
(State or country) MASS

PARENTS
17 NAME OF FATHER GEORGE TIRRELL
18 BIRTHPLACE OF FATHER (City) BOSTON
(State or country) MASS
19 MAIDEN NAME OF MOTHER BETHILDA LARSON
20 BIRTHPLACE OF MOTHER (City) SWEDEN
(State or country)

21 Informant MRS. ALICE TIRRELL
(Address) 234 SHORE DRIVE WINTHROP

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
R. R. Gorman
(Signature of Agent of Board of Health or other)
14407 12/26/62
(Official Designation) (Date of Issue of Permit)

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of mean dying, failure, t means compli- caused
f any, rise to (a), under- last.
contrib- but not terminal on given.
apter 137 , requires to print or cause or death on icates, and Acts of res Physi- nt or type signature.
25 1963
Disease
Heart
Hypertrophic
Hypertensive
H.S.N.D.

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar

250

OUT - OF - TOWN

The Commonwealth of Massachusetts
KEVIN H. WHITE
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

PLACE OF DEATH
1 SUFFOLK (County)
BOSTON (City or Town)

(City or Town making this return)

Registered No. 12863

En route to East Boston Relief Station St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME JOHN J. USSEGLIO
(First Name) (Middle Name) (Last Name)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) WW 1

(a) Residence, No. 78 Marshall Street St. Winthrop, Massachusetts
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ... years ... months ... days. In place of residence 14 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December (Month) 31, (Day) 1962 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Arteriosclerotic heart disease,
Coronary occlusion.

5 Accident, suicide, or homicide (specify)
Date and hour of injury ... 19.
IF ACCIDENTAL, was injury causally related to the death?
Where did Injury occur? (City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)
Manner of Injury (How did injury occur?)
Nature of Injury
While at work? Was autopsy performed? No.

6 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Michael A. Luongo, M. D.
Michael A. Luongo, M.D.
(Print or Type Name)
(Address) Boston Date 12/31 1962

7 Winthrop Cemetery, Winthrop
Place of Burial, or Cremation. (City or Town)
DATE OF BURIAL January 4th 1963

8 NAME OF FUNERAL DIRECTOR Richard C. Kirby, Inc.
ADDRESS 917 Bennington St., E.Boston

Received and filed JAN 3, 1963 19
Charles F. Mackie
(Registrar)

A TRUE COPY ATTEST:

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male
10 COLOR White
11 SINGLE (write the word) MARRIED WIDOWED DIVORCED UNKNOWN Married

12 If married, widowed, or divorced HUSBAND of Theresa V. Cavagnaro
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

13 DATE OF BIRTH Dec.27,1898

14 AGE 64 Years 0 Months 4 Days | If under 24 hours ... Hours ... Minutes

15 Usual Occupation Painter-retired
(Kind of work done during most of working life)

16 Industry or Business Painting

17 Social Security No. 031-09-3093

18 BIRTHPLACE (City) Boston
(State or country) Mass.

PARENTS
19 NAME OF FATHER Joseph Usseglio
20 BIRTHPLACE OF FATHER (City)
(State or country) Italy
21 MAIDEN NAME OF MOTHER Aurelia Morello
22 BIRTHPLACE OF MOTHER (City)
(State or country) Italy

23 Informant Mrs. Theresa V. Usseglio-wife
(Address) 78 Marshall St., Winthrop

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
R. K. Garmon
(Signature of Agent of Board of Health or other)
14494 1/2/63
(Official Designation) (Date of Issue of Permit)

OFFICIAL

R-303
burial permit
of Health
Agent.

MEDICAL EXAMINERS should state CAUSE AND MANNER of DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for additional information. See also Chap. 38, §§ 6, 20; Chap. 46, §§ 9, 10; Chap. 114, §§ 44-48.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

OM-9-61-931348

B 25 1963

A TRUE COPY ATTEST:

Charles H. Mackie

City Registrar